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1954-55

MEDICAL DISTRICT MEETINGS
OCTOBER 11 - 15, 1954

THE N.Y. ACADEMY OF MEDICINE
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Volume XLI **JULY, 1954** **No. 1**

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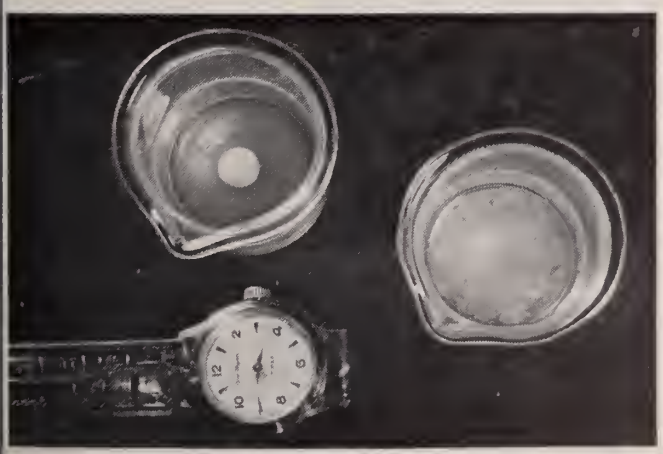
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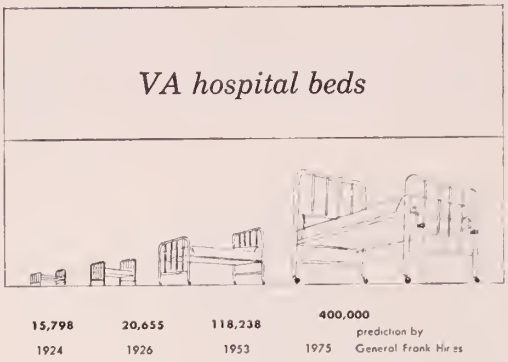
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1954 MEDICAL DISTRICT MEETINGS

"A" Marianna	October 11
"B" Sanford	October 13
"C" Sarasota	October 15
"D" Vero Beach	October 14



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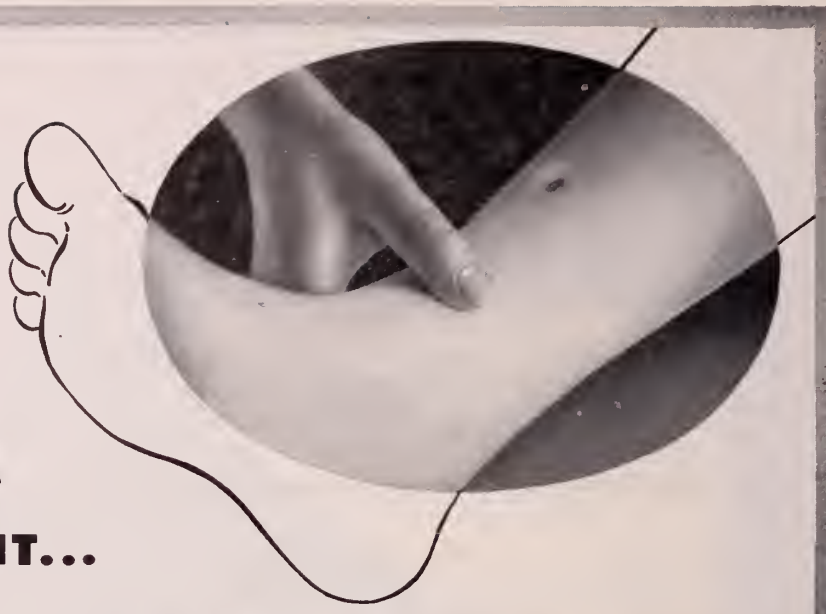
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1. Abramsan, Julius, Bresnick, Elliatt, and Sapienza, P. L.: *New England Jour. Med.*, 243:44, July 13, 1950.

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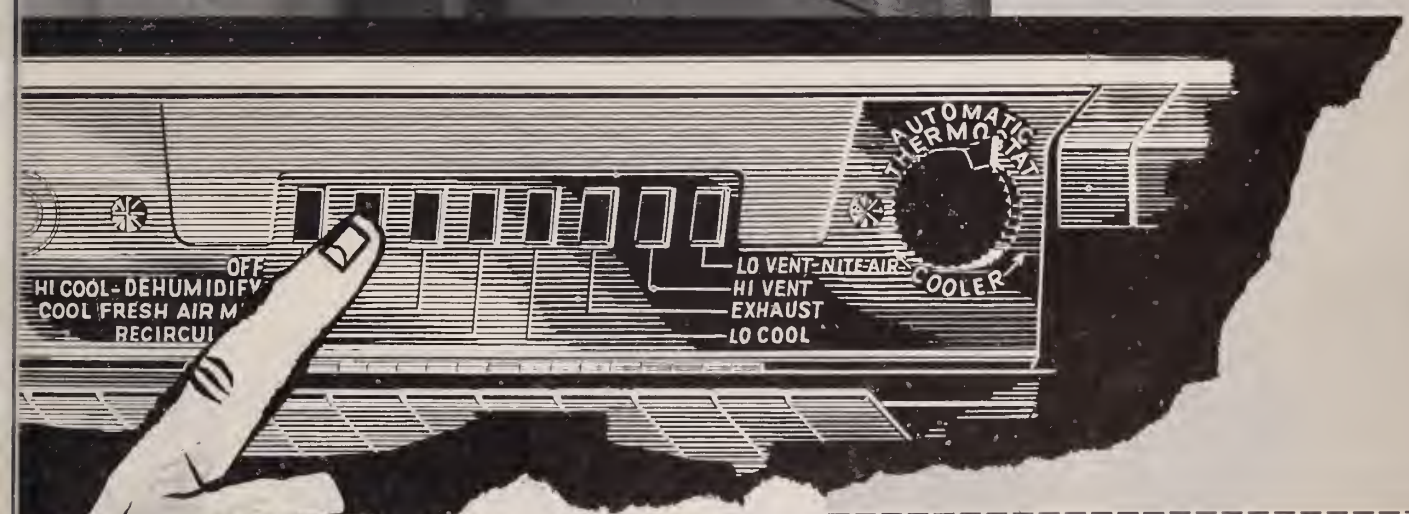
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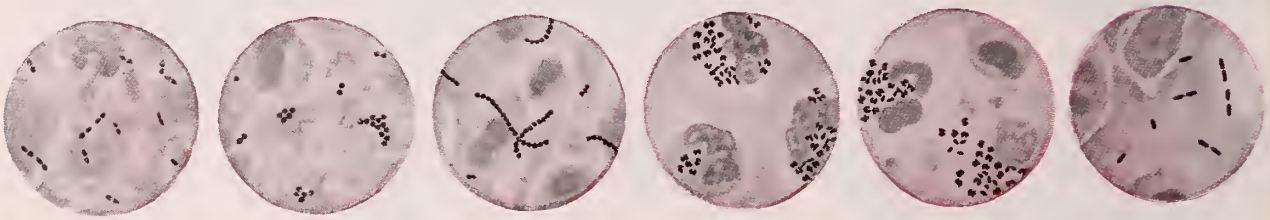
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1. Greenblatt, R. B., and Kupperman, H. S.: M. Clin. North America *30*:576 (May) 1946. 2. McGavack, T. H., in Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc., 1953, p. 225.

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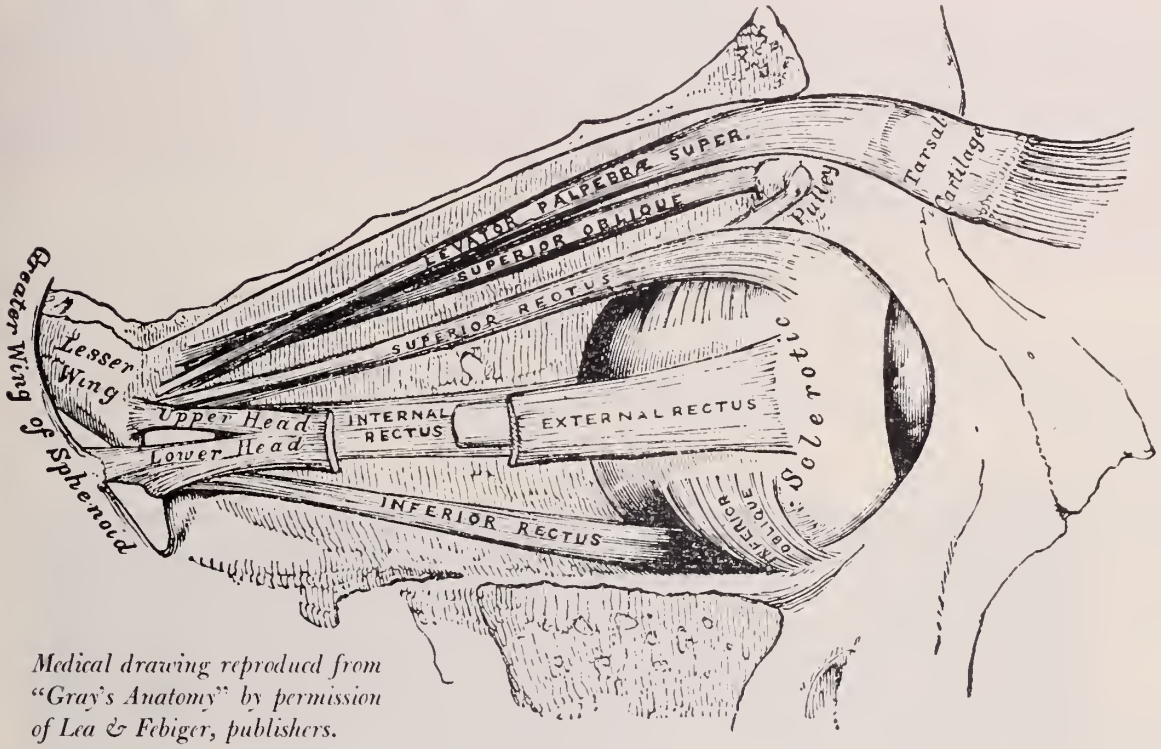
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	Vestibular damage % of patients		
	Mild	*Moderate*	*Total*
Streptomycin	12	6	18
Dihydrostreptomycin	6	0	6
Distrycin	0	0	0

	Cochlear damage % of patients		
	Mild	*Moderate*	*Total*
Streptomycin	0	0	0
Dihydrostreptomycin	12	3	15
Distrycin	0	0	0

**Heck, W.E.; Lynch, W.J., and Graves, H.L.: Acta oto-laryng. 43:416, 1953.*

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2 Blood pressure is lowered by centrally medicated action; there is no ganglionic or adrenergic blocking.

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4 Hypotensive action is independent of alterations in heart rate.

5 Cardiac output is not reduced.

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9 No dangerous toxic effects from oral administration, no deaths attributable to Veriloid have been reported. Side actions of sialorrhea, substernal burning, bradycardia, nausea, and vomiting (due to over dosage) are readily overcome and thereafter avoided by dosage adjustment.

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11 Tolerance or idiosyncrasy rarely develops; allergic reactions have not been encountered. Hence tablets Veriloid can be given for the long treatment needed in severe hypertension.

12 Continuing therapy with Veriloid has not led to interference with appetite or with excretory function.

13 Because of its rapidly induced, prolonged action (6 to 8 hours), tablets Veriloid provide around the clock hypotensive effect from 4 doses daily, make today's dosage effective today, and usually prevent hypertensive "spiking" during the night.

14 A notable safety factor in intravenous administration: *extent to which blood pressure is lowered is directly within the physician's control.*

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For immediate reduction of critically elevated blood pressure in hypertensive emergencies such as hypertensive states accompanying cerebral vascular disease, hypertensive crisis (encephalopathy), the toxemias of pregnancy. It lowers the blood pressure promptly, to any degree the physician desires, and with notable safety.[3] If excessive hypotensive and bradycardic effects should be invoked they are readily overcome by simple means. Supplied in boxes of six 5 cc. ampuls. The solution contains 0.4 mg. of Veriloid per cc.

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For maintenance of blood pressure in such critical instances, and for primary use in less critical situations which do not show the same immediate urgency. Provides 1.0 mg. of Veriloid per cc. in isotonic aqueous solution incorporating one per cent procaine hydrochloride. A single dose lowers the blood pressure significantly, reaching its maximum hypotensive effect in 60 to 90 minutes. By repeated injections (every 3 to 6 hours) blood pressure may be kept depressed for hours or days if necessary.[4] Supplied in boxes of six 2 cc. ampuls. Complete instructions as to dosage and administration accompany every ampul of the parenteral preparations of Veriloid and should be noted carefully.

1. Kauntze, R., and Trounce, J.: Treatment of Arterial Hypertension with Veriloid (Veratrum Viride), Lancet 2:1002 (Dec. 1) 1951.
2. Wilkins, R. W.: Combination of Drugs in the Treatment of Essential Hypertension, Mississippi Doctor *30*:359 (Apr.) 1953.
3. Stearns, N. S. and Ellis, L. B.: Acute Effects of Intravenous Administration of a Preparation of Veratrum Viride in Patients with Severe Forms of Hypertensive Disease, New England J. Med. *246*:397 (Mar. 13) 1952.
4. Moyer, J. H., and Johnson, I.: Intramuscular Veriloid (Aqueous Solution) As a Hypotensive Agent, Am. J. M. Sc. *226*:477 (Nov.) 1953.

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XLI | Jacksonville, Florida, July, 1954 | No. 1

Skin Response to Trafuril: Possible Test for Rheumatic Activity

MILTON S. SASLAW, M.D.
AND
MURRAY M. STREITFELD, Ph.D.
MIAMI

The evaluation of rheumatic activity has been a distressing problem to most physicians at one time or another. If a simple test could be devised to help evaluate this activity with some degree of accuracy, the practice of cardiology, particularly in children, would be greatly facilitated.

For some time now, we, at the National Children's Cardiac Hospital in Miami, have been looking for such a test. About a year and a half ago, Nassim and Banner,[1] in England, reported their experience with the tetrahydrofurfuryl ester of nicotinic acid. This drug, under the trade name Trafuril (Ciba),* has been used abroad as a rubefacient treatment in inflammatory joint diseases. Reddening of the skin normally follows topical application of this drug. Nassim and Banner[1] noted that in 5 cases of active rheumatoid arthritis reddening failed to appear. When the activity was controlled with ACTH or cortisone, the usual erythematous response was observed.

It occurred to us that the skin response to Trafuril might serve as a clue to the presence or absence of rheumatic activity. Through the courtesy of Ciba & Co., Ltd., of London, we were able to obtain this drug, which is as yet unavailable in the United States. The drug was supplied to us in the form of a lanolin-Vaseline ointment containing 5 per cent of the ester. First, we skin-tested the inpatients and outpatients of the National Children's Cardiac Hospital in Miami. Later, the study was extended to patients at five other institutions, including Children's Heart Hospital, Philadelphia; Gallinger Municipal Hospital, Washington, D. C.; Irvington House, New York; Jackson Memorial Hospital, Miami; and King's County Hospital, Brooklyn, N. Y.†

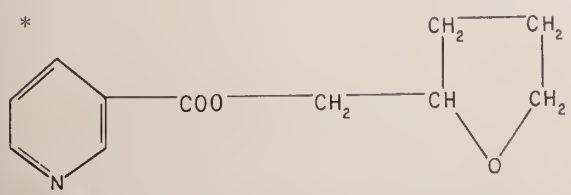
In all, 376 white and Negro children several months to 18 years of age have been tested to date. These included patients with active and inactive rheumatic fever or rheumatic heart disease, congenital heart disease, and a number of miscellaneous nonrheumatic conditions, as well as normal, healthy subjects.

The test was performed by rubbing 70 mg. of Trafuril ointment into an area an inch and a half in diameter on the volar aspect of the forearm, using 35 circular motions for uniformity. The control ointment base was applied in the same way.

The optimal time for reading the reactions was determined by observations at five minute intervals for three hours in the first 31 patients. The best differentiation could be made in 30 minutes, with readings at 10 minute intervals. The ointment was removed by several wipings with alcohol pledgets at the end of 30 minutes, or sooner if hyperemia of considerable degree occurred.

Read before the District Meetings of the Florida Medical Association, Tallahassee, Oct. 19, 1953, and Tampa, Oct. 21, 1953.

Supported in part by funds from Ciba Pharmaceutical Products, Inc., Summit, N. J.



†We acknowledge with thanks the cooperation of Drs. Francisco A. Hernandez, Gene H. Stollerman, Ella Roberts, Joseph Fazekas, Richard S. Gubner, Franz H. Stewart, Scheffel H. Wright and Warren W. Quillian, and the medical and nursing staffs of these institutions.

Blood counts, urinalyses, sedimentation rate determinations, electrocardiograms, and temperature recordings were taken in the first 31 cases, prior to, and 24 hours and one week after application of the ointment.

Reactions to the ointment consisted of hyperemia and edema in the area at the site of application, as well as in the surrounding area called the spread zone.

The color reactions were graded as follows: zero, blanching without edema; minus, no visible color change; plus-minus, barely perceptible hyperemia; 1 plus to 2 plus, hyperemia of increasing intensity. Readings of the reactions could best be made by daylight.

In a "typical" normal response (fig. 1), hyperemia and/or edema developed within 30 minutes. The hyperemia varied from 1 plus to 2 plus intensity in the ointment area, and minus to 2 plus intensity in the spread zone, where it sometimes extended as much as 1 inch beyond the site of application. Edema alone, without hyperemia, was considered a typical response. Often as edema developed, hyperemia faded. If edema was absent and hyperemia was barely perceptible (plus-minus) in the ointment area and 1 plus to 2 plus in the spread zone, extending more than ¼ inch beyond the site of application, the reaction was classified as typical.

An "atypical" response (fig. 2) was usually characterized by blanching or no visible color change at the ointment site or spread zone within 30 minutes. In some cases, hyperemia occurred in the spread zone only, but this, in contrast to the typical reaction, was limited to less than ⅛ inch if 1 plus in intensity or less than ¼ inch if plus-minus in intensity. In other cases, the atypical response consisted of the development of barely perceptible (plus-minus) hyperemia in the ointment area within 10 minutes, fading out completely by the end of 30 minutes.

Results

The skin responses to Trafuril in the 376 patients are shown in tables 1 and 2. Table 1 shows the results in 251 patients with rheumatic fever and rheumatic heart disease (active and inactive).

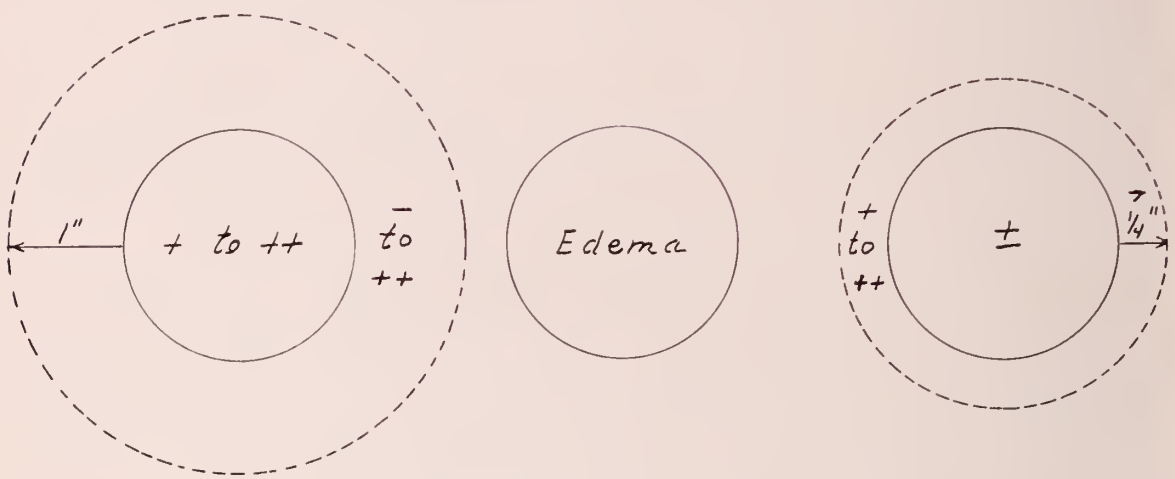


Fig. 1.—Typical Responses to Trafuril

Table 1. — Skin Responses to Trafuril of 376 Children, Including 251 With Rheumatic Disease

Rheumatic Diagnosis	Number of Cases	Skin Responses to Trafuril		
		Typical	Atypical	Doubtful
Active	24	2	22	—
Inactive	201	199*	2	—
Suppressed	5	5	—	—
Clinically indeterminate	21	11	10	—
Total rheumatic disease	251	217	34	0
Total non-rheumatic disease	125	111	13	1
Total	376	328	47	1

*Includes 20 patients with elevated sedimentation rates, in 11 unexplained and in 9 attributable to other conditions as follows: 3 diphtheria toxoid inoculation, 2 tonsillitis, 1 menstruation, 1 cystitis, 1 pyelitis and 1 dental caries.

Twenty-two of 24 patients in whom the disease was active gave atypical responses, while only 2 of 201 in whom it was inactive responded atypically. All of the 5 patients in whom the activity was suppressed by cortisone or aminopyrine gave a typical reaction. Only 13 of 125 patients with nonrheumatic disease (table 2) gave atypical reactions. Five of these were in cases of tonsillitis or streptococcal sore throat. Two children with subacute glomerulonephritis responded typically.

Toxicity studies in the first 31 cases failed to reveal any changes in blood counts, sedimentation rates, urinalyses, body temperature or electrocardiograms. A few patients reported mild, transient itching and/or a warm feeling at the site of application. On three occasions, a 5 per cent Pyribenzamine cream was applied to relieve the itching.

Table 2. — Skin Responses to Trafuril of 125 Children With Nonrheumatic Disease

Group	Number of Cases	Skin Responses to Trafuril		
		Typical	Atypical	Doubtful
Normal	63	59	3	1
Congenital heart disease	47	43	4	—
Miscellaneous				
Glomerulonephritis	2	2	—	—
Tonsillitis	5	—	5	—
Others	8*	7	1†	—
Total nonrheumatic disease	125	111	13	1

*Includes 1 case each of hyperthyroidism, pneumonia, Riley's syndrome, psycbic vomiting, bronchiectasis, pyelonephritis, idiopathic endothedial fibroelastosis, and skull fracture.
†Skull fracture.

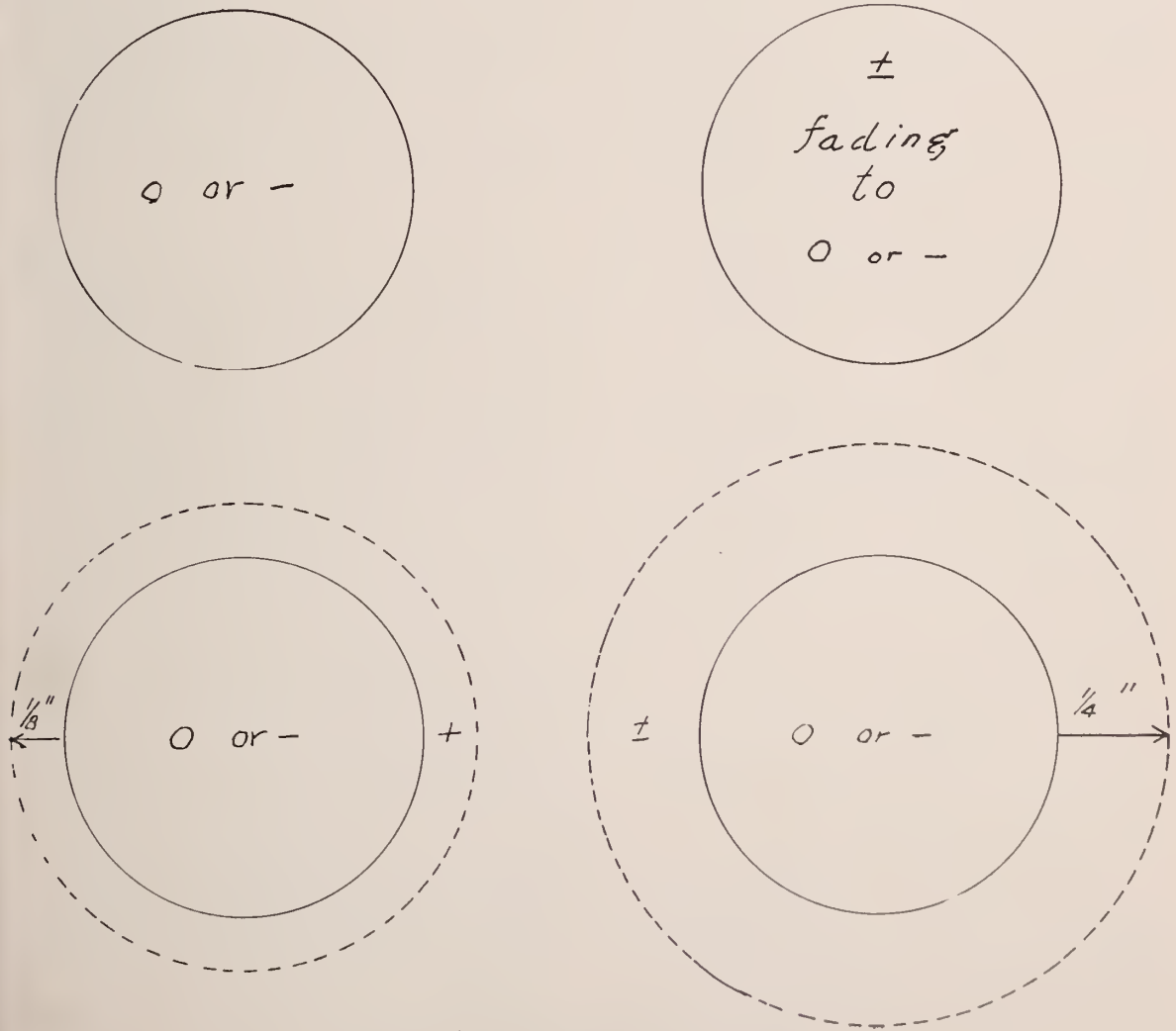


Fig. 2.—Atypical Responses to Trafuril

Discussion

The fact that over 90 per cent of the patients with active rheumatic fever gave atypical reactions to the topical application of 5 per cent Trafuril ointment, while about 1 per cent of those in whom the disease was inactive gave this response, strongly indicates the possible use of Trafuril inunction as a means of distinguishing active from inactive rheumatic fever, once the rheumatic diagnosis is established.

Little can be said about the 21 children in our series in whom activity could not be determined clinically. Eleven responded typically and 10 atypically. If further studies confirm the present findings, the Trafuril test may well serve to assist the clinician in the final evaluation of such indeterminate cases.

Less than 5 per cent of the normal children and 8.5 per cent of those with congenital heart disease gave atypical reactions. Our miscellaneous group with nonrheumatic illnesses is too small to warrant any conclusions. It is of interest that 2 children with subacute glomerulonephritis, a disease closely related to rheumatic fever, gave the typical response. It is also noteworthy that 5 children with tonsillitis responded atypically. One of these was found to have a Group A beta hemolytic streptococcus in her throat culture, and her illness later was diagnosed as scarlet fever. Unfortunately, no throat cultures were taken from the other 4 children.

Another potential use of the Trafuril skin response may be in following changes in clinical activity. In 4 of our patients, in whom the clinical activity changed during the course of the study, the skin reaction was observed to reflect such differences in activity. When activity was suppressed by cortisone in 4 patients or by aminopyrine in 1 patient, the skin response was typical.

The present study has been limited to children. There is some indication that this procedure may require modification as to time of reading and ointment concentration for use in adults.

The basic mechanism of this reaction is unknown. The test may reflect:

1. Altered reactivity in the smaller vessels of the peripheral circulation in patients with rheumatic activity. Vascular changes in patients with rheumatoid arthritis have been reported.[2,3]

2. Disturbances in nicotinic acid metabolism. Nicotinic acid is related to carbohydrate metabolism. That carbohydrate metabolism is disturbed in rheumatoid arthritis has been indicated by altered tissue requirements for ATP.[4] Furthermore, ATP is a requisite for skeletal and heart muscle contraction.[5] Serum polysaccharide elevation has been observed during rheumatic fever activity.[6]

3. Changes in hyaluronic acid metabolism leading to either increased production of a barrier to drug absorption or increased diffusion of the absorbed drug and/or drug products. Disturbances in hyaluronic acid metabolism in rheumatic diseases have been suggested.[7] The high antihyaluronidase titers observed in early rheumatic fever and some cases of rheumatoid arthritis may be of correlative interest.[8]

Many more subjects, including normal persons, those with rheumatic disease and those with collagen vascular diseases and nonrelated illnesses, will have to be studied before conclusions can be drawn as to the usefulness and limitations of skin testing with the tetrahydrofurfuryl ester of nicotinic acid. Other nicotinic acid derivatives are currently under investigation. Attempts are being made to determine the mechanism of action of this response.

Summary

An inunction of 5 per cent tetrahydrofurfuryl ester of nicotinic acid was applied to the forearms of 376 children. It produced a typical cutaneous response of hyperemia and/or edema in normal children, those with congenital heart disease, those in whom the rheumatic condition was inactive and those in whom the rheumatic activity was suppressed by cortisone or aminopyrine.

Twenty-two of 24 children judged clinically to be suffering from active rheumatic fever failed to show this typical response. Their reaction was atypical and consisted of either no color change or blanching at the site of application of the ointment. The skin response paralleled changes in rheumatic activity status. The atypical response was observed also in 5 cases of acute tonsillitis. The underlying mechanism and specificity of the reaction are under investigation.

References

1. Nassim, J. R., and Banner, H.: Skin Response to Local Application of a Nicotinic Acid Ester in Rheumatoid Arthritis, Lancet 1:699 (April 5) 1952.
2. Davidson, L. S. P., in Rheumatic Diseases, Based on Proceedings of Seventh International Congress on Rheumatic Disease; prepared by Committee on Publications, American Rheumatism Association, Charles H. Slocum, chairman, Philadelphia. W. B. Saunders Company, 1952, pp. 6-7.
3. Patterson, M. B., and Freyberg, R. H.: *ibid,* pp. 345-350.
4. Haydu, C. G.: Rheumatic Arthritis Therapy; a Rationale and the Use of Chloroquine Diphosphate, Am. J. M. Sc. 225:71-75 (Jan.) 1953.

5. Szent Györgi, A.: Chemistry of Muscular Contraction, ed. 2, New York, Academic Press, Inc., 1951.
6. Shetlar, M. R., and others: Response of the Serum Polysaccharide Fractions and Protein Fractions Following Cortisone Treatment of Patients with Rheumatic Fever, J. Lab. & Clin. Med. 39:372-382 (March) 1952.
7. Bywaters, E. G. L.; Holhorow, E. J., and Keech, M. K.: Reconstitution of Dermal Barrier to Dye Spread after Hyaluronidase Injection, Brit. M. J. 2:1178-1183 (Nov. 17) 1951.
8. Rantz, L. A.; Di Caprio, J. M., and Randall, E.: Antistreptolysin O and Antihyaluronidase Titers in Health and in Various Diseases, Am. J. M. Sc. 224:194-200 (Aug.) 1952.

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Digitalis Brought Up To Date

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It was my unfortunate experience recently to see for the first time a male patient about 60 years of age with a history of cardiac decompensation of three years' duration. He was not particularly dyspneic and had no peripheral edema. His complaints were weakness and some anorexia, and diarrhea of two days' duration. Therapeutic management consisted of a low salt diet, digitalis, ion exchange resins and mercurials. When asked if he was up and about, he said, "Yes," and immediately demonstrated his ability to walk 20 steps on the level floor, sat down, coughed, and was dead within a minute. Comment: Therapy for cardiac decompensation successful; patient died dry.

My postmortem in this case consisted of a helpless and awesome glance at the array of drugs that kept him dry.

The second case is commonly seen, a patient in his sixties with heart disease of many years' duration in which he was intermittently in and out of decompensation; despite a therapeutic regimen of low salt diet, mercurial diuretics, and digitalis pushed to its maximum dosage, there developed an intractable edema and wet lungs, and he expired. Comment: Therapy for cardiac decompensation unsuccessful, patient dies wet.

The organic basis for either case is not within the scope of this paper. The cases represent polarity of results in the current treatment of cardiac decompensation. It would be well to visualize them where and when they may apply in the present discussion. They do present the extremes in the present therapy of cardiac decompensation.

In 1910, Wenkeback[1] stated, "Digitalis treatment is one of the most important and serious duties of the general physician. It demands a great deal of skill, power of observation, keen interest, and experience. A long life is too short to learn enough about this wonderful drug."

In 1953, it may be stated that whereas specifics and empiric specifics have been replaced, such as the arsenicals in syphilis, quinine in malaria, and now perhaps emetine in amebiasis, but digitalis, including its glycosidal components, remains the most important and dependable drug, despite the challenge of sodium manipulation, in the treatment of the decompensated heart.

Chemically, the digitalis group consists of three components (fig. 1):[2]

1. Phenanthrene nucleus, which physicians recognize as being common to the sterols (vitamin D), sex hormones (estrogens and androgens), bile acids, and adrenocortical hormones.
2. A sugar which has to do with its solubility and diffusion.
3. A lactone which endows the glycoside (cardiac aglycone) with its therapeutic characteristics.

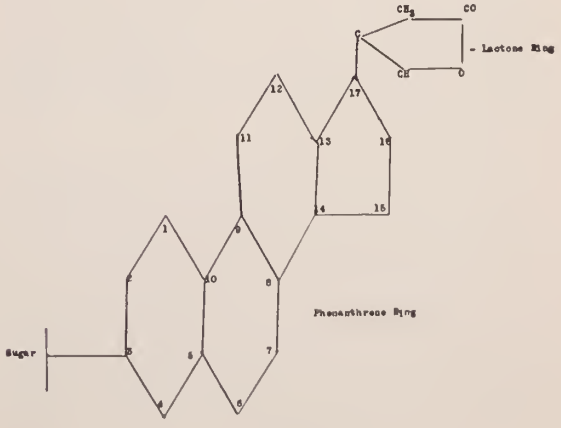


Figure 1

From the Veterans Administration Center, Bay Pines.
Read before the Southwestern Medical District Meeting, Tampa, Oct. 21, 1953.

Digitoxigenin, which is Digitoxin minus the sugar, is an intermediate between the bile acids and the sex hormones.

The similarity of the intermediate products would lead one to consider the digitalis group as having some of the metabolic aspects common to the sterols, estrogens and adrenocortical hormones.

Like the adrenocortical hormones, the glycosides of the digitalis group can protect the animal against lethal doses of potassium salts. A question arises in our minds; when treating heart failure, are we treating a metabolic fault?

Figure 2 demonstrates the relationship between Digitalis purpurea (purple), American grown variety of digitalis, and Digitalis lanata (white), entirely European-grown up until World War II, when cultivation was started in America. Intermediate hydrolytic products have been omitted for simplicity.

Figure 2

Digitalis lanata — Digilanid	46%	Digilanid A — Digitoxin
	17%	Digilanid B — Gitoxin
	37%	Digilanid C — Digoxin
Digitalis purpurea		Purpura Glycoside A — Digitoxin
		Purpura Glycoside B — Gitoxin
		Purpura Glycoside C — Gitalin

As obviously noted, the glycosides Digitoxin and Gitoxin are common to both varieties. Digitalis purpurea has been reported to have 16 or more glycosides,[1] and one may assume by analogy, the same may be more or less true of Digitalis lanata.

The glycosides of squill differ from the digitalis glycosides by the addition of a carbon to its lactone ring. The strophanthus glycosides, which include ouabain, differ in the structure of their sugars. Thevetic glycoside has for its sugar a glucose and a digitalose.[3] Because of chemical and therapeutic similarity, when speaking of the digitalis group or series, one includes Digitalis purpurea, Digitalis lanata, Strophanthus, Squill and Thevetia.

Prior to 1930, digitalis therapy consisted of the use of the leaf, tincture, or infusion. The present day clinician subscribes to the leaf or the purified tincture for intravenous use and to one of the numerous purified glycosides of digitalis. One often hears or reads the dictum that we should use, know, or master one glycosidal drug, assuming, no doubt, that one is fully acquainted with the use of the leaf.

It is doubtful that we are at any time master of the drug, because the treatment of cardiac decompensation is not limited to digitalis alone. Digitalis therapy is affected by such factors as prolonged low sodium diets, mercurial diuretics, and the immeasurable human metabolic differences which prevent individuals from reacting to a nominal dosage of a drug to an equal degree. Mechanical factors, and probably the high output cardiac failures,[4] such as hyperthyroidism, anemia and arteriovenous fistula, do not depend wholly on digitalization.

For the sake of the intractable edemas of cardiac failure, one should be acquainted with the whole digitalis system and not the part. A single glycoside is not suitable for all cases. Present trend does not recommend the use of exchange values because of difference in absorption between the alimentary and intravenous routes of different glycosides.

The clinicians are generally limited to one or two of the following drugs:

Digitalis Leaf
Digitoxin
Digoxin
Gitalin

The four drugs listed should not be difficult to know and use. The confusion lies not in these few basic drugs but in the babel of proprietary names that does not permit the physician using Digalen to talk to a physician using Purodigin or Cardigin or Unidigin.

The accompanying list (table 1) of commercial digitalis products, though incomplete, is offered not only as illustration but also for reference.[5,6] Squill and Strophanthus were included inasmuch as they are usually described in the digitalis group.

In discussion of the chemical make-up of the digitalis group, the relationship was brought out that the sterid portion was common to the sterols, bile, estrogens, androgens, and adrenocortical hormones. The latter sterids have tissue specificities or metabolic effect. The thought was broached that Digitalis when used in myocardial insufficiency might be correcting a metabolic fault, or supplying a hormonal equivalent. The tissue specificity is strongly suggested in Rothlin's report[3,7] that the heart takes up the digitalis per unit of weight 35 times as much, the abdominal organs 4.5 times as much as the remaining organs of eviscerated body.

Table 1. — Commercially Available Preparations of Digitalis and Glycosides

DIGITOXIN	
Cardigin	National Drug
Crystodigin	Lilly
Digisidin	Winthrop-Stearns
Digitaline Nativelle	Varick
Digithyl	Cole
Purodigin	Wyeth
Unidigin	Merrell
Digitoxin	Chicago Pharmacal
DIGOXIN	
Cedilanid	Sandoz
Digoxin	Burroughs Wellcome
WHOLE LEAF	
Digalen Tablets	Hoffmann-LaRoche
Ampules	
Digiclara	Chemico
Digicotin	Grant
Digifolin	Ciba
Digifortis	Parke, Davis
Digiglusin	Lilly
Digilanid — Ampules — IM	
Ampules — IV	Sandoz
Suppositories	
Tablets	
Digiseals	Harvey
Digitalin Potent	Merck
Digitalis Duo-Test	McNeil
Digitalis Injection	Upjohn
Digitalone	Parke, Davis
Digitan — Ampules	
Powder	Merck
Tablet	
Digitol (Tincture)	Sharp & Dohme
Digitora	Upjohn
Enterdigalis	Chicago Pharmacal
GITALIN	
Gitaligin	White
SQUILL	
Scillaren A or B	Sandoz
Uriginin	Lederle
STROPHANTHUS	
(a) Gratus	
Ouabain	Lilly
Ouabain	Hynson, Westcott
Ouabain	Smith, Carroll Dunham
(b) Kombé	
K. Strophanthin	Abbott
K. Strophanthin	Burroughs Wellcome
Strophosid	Sandoz

We can divide the effects of digitalis therapy into nontoxic and toxic phases. Unfortunately, the therapeutic effects are not always within the nontoxic phase, and as digitalis therapy becomes less and less efficacious, it approaches or passes into the toxic stage before achieving the therapeutic effect. We have learned to accept toxicity as a necessary sign of a therapeutic result. There is reason to believe the acceptance of toxicity in therapy is due to our ignorance.

The nontoxic and toxic characteristics of digitalis therapy are as listed.[2,3]

Nontoxic Effects of Digitalis

1. Vagal. — Decreased radial and apical pulse rates with no specific electrocardiographic changes reversed by atropine or exercise.
2. Conduction Tissue. — Functional slowing with electrocardiographic manifestations of increased P-R interval. Light digitalization will permit reversal with atropine or exercise, becoming less effective as the direct effect on the functional tissue becomes greater than the vagal effect.
3. Myocardial. — Smaller heart resulting in decreased venous pressure, manifesting electrocardiographic changes, such as RS-T depression, and tendency to T wave inversion without the presence of Q wave.

Toxic Effects of Digitalis

1. Gastrointestinal
   - Anorexia
   - Vomiting
   - Occasional diarrhea
2. Visual Disturbance
3. Cardiac Arrythmias
   - Ectopic beats
   - Coupling
   - Dropped beats
     - Auriculoventricular block
     - Auriculoventricular dissociation
   - Paroxysmal tachycardia
     - Auricular
     - Ventricular - bidirectional
   - Auricular fibrillation
   - Ventricular fibrillation
   - Pulsus alternans
4. Nervous System
   - Confusion
   - Delirium

Coincidently with the introduction of purified glycoside therapy since 1930, there has been an increase in the occurrence of clinical digitalis toxicity. The John Sealy Hospital Report[3,8] is of interest in that 1 case of digitalis toxicity was reported each year between 1930 and 1939, whereas the ratio was 1:300 in 1940, 1:50 in 1941, 1:20 in 1942, and 1:15 in 1943. With such figures one wonders if there be any ratio today, for we have gone so far as to accept and condone more or less limited toxicity as a necessary end result and evil in the course of treatment of the decompensated heart. In addition to the digitalis therapy, we are

using the low salt diet, mercurials, and ion exchange resins as though they were an unrelated and benign factor in digitalis toxicity.

The low salt diet and diuretics aim at the treatment of decompensation by the manipulation of the sodium ion which predominates in the extracellular compartment, thus relieving edema. We have overemphasized this mechanism in our therapy as though it were the prime factor in heart disease, overlooking the intracellular compartment, which, when involved, is truly heart disease. The predominant ion in the intracellular electrolyte is potassium. Potassium is common to both skeletal and cardiac muscle; we will confine our thinking in this paper to the myocardium.

Some of the concluding results of studies relating to potassium applicable to this discussion are listed.

The potassium content of the left ventricle is found to be higher than that of the right ventricle.[9,10]

Exercise fatigue, anoxia, and injury cause potassium to leave the cell (flight of potassium).

Corticosteroid returns potassium to the cells.[11]

Digitalis, a sterid, acting like this hormone also restores potassium to the cell (potassium return).[12]

There is a negative potassium balance in the heart tissue during myocardial anoxia or insufficiency.[13,14]

Cardiac glycosides have been found to protect normal animals against potassium poisoning, to lower the serum potassium, and to prolong life in adrenalectomized animals.[15]

Overdigitalization, like injury, drives potassium out of the cell.[14]

In mercurial diuresis, the potassium loss in the diuresis was found to be larger than the total amount of extracellular loss of potassium;[16,17] so there seems to be unquestionably an intracellular loss of potassium.

Thus, mercurial diuresis leaves the patient relatively alkalotic with loss of intracellular potassium and a gain of intracellular sodium.[16]

We conclude from these observations:

1. There is a flight of potassium from the cell in the decompensated heart.
2. Digitalis restores potassium to the cell.
3. Mercurial diuresis causes a flight of potassium from the cell by its demands on the homeostatic apparatus both within and out of the cell, disturbing the extracellular and intracellular electrolytic balance.
4. Digitalis overdosage causes flight of potassium from the cell.

It would seem that we have two recognized forms of therapy for treating the same condition which are in opposition to each other.

There are further factors for consideration. Changes in the body potassium alter the threshold of the heart to the toxic action of digitalis.[17] Increased myocardial sensitivity to digitalis occurs in the presence of intracellular hypopotassemia. Digitalis toxicity has followed successful mercurial diuresis and diarrheas.[18] In the past such toxicity has been explained on the basis of mobilization of the digitalis from the peripheral extracellular fluid. The digitalis toxicity which of recent years has increased in incidence has in part, at least, been due to an induced intracellular potassium deficiency. Please note the recent empiric use of potassium chlorides for the reversal of some of the arrhythmias of alleged Digitalis toxicity. Colloquially speaking, often when we speak of Digitalis toxicity, we may be hanging the wrong man.

Since 1951 our standardization of digitalis has been against the U.S.P. Digitalis Reference Standard,[19] which is based upon the intravenous injection of the drug into a pigeon until death occurs. The unknown is compared and adjusted so that 0.1 Gm. of the unknown has the potency of 0.1 Gm. of the standard or one U.S.P. Digitalis Unit.

One U.S.P. Digitalis Unit equals 1.3 cat units. To many of us, the change from cat units to U.S.P. Digitalis Units represents the same confusional changes that occurred when electolytic levels were reported in milliequivalents instead of milligrams. Present literature still discusses digitalis using cat unit as a reference point. We will not deviate. The cat unit represents the amount of digitalis drug or glycoside that will kill 1 Kg. of cat within one and one-half hours when given intravenously.

In table 2 are listed potency equivalents to the cat unit of commonly used cardioactive glycosides. They cannot be used as cat unit exchanges because of differences in alimentary and intravenous absorption and assimilation. We may some day deny this last statement.

A listing of the clinical characteristics which would influence the choice of digitalis therapy is presented in table 3.

Table 2. — Relative Potency of Common Cardiac Glycosides to 1 Cat Unit

Drug in Milligrams	Oral Digitalizing Dose in Milligrams	Cat Unit Equivalent
Ouabain 0.1 Strophanthin-K 0.13 Digoxin 0.2	3.75	19.5 in 24 hrs.
Lanatoside C - 0.28	7.5	27 in 72 hrs.
Digilanid 0.33	3.3 to 8.9	10-27 in 24-48 hrs.
Digitoxin 0.42	1.2	3 single dose
Thevetin 0.85		
Uriginin 0.2	8-12 18	40-60 in 4 days 90 in 5-6 days
Gitalin 0.25	5.6	22.4

As a general rule 3 to 5 cat units of these drugs given intravenously comprise a digitalizing dose.

What are the characteristics of an ideal cardioactive glycoside? They are judged as follows:

1. Quick acting (short latent period) for the acute cardiac failure, for example, Ouabain, Digoxin, and Cedilanid.
2. Moderate accumulation to assure digitalization, for example, Digoxin.
3. Medium dissipation to prevent underdigitalization, for example, Gitalin.
4. Wide therapeutic toxic ratio to avoid toxicity, for example, Gitalin.
5. Maintenance dose effective by single daily dose, for example, Digoxin and Gitalin. Digitoxin would qualify for its easy maintenance, but it has been criticized for its long dissipation period and tendency to prolonged toxicity. Of course, in this paper we have questioned that all alleged digitalis toxicity is due to digitalis.

What are some of the problems met in cardiac decompensation?

There is the patient with recently developing cardiac decompensation. He presents no problem. Digitalization may be induced gradually with the digitalis of choice.

In the acute emergency, acute congestive failure requires two glycosides or the equivalent. At first a fast-acting glycoside is used, Ouabain intravenously, or Cedilanid intravenously, or Digoxin intravenously or intramuscularly, followed with a maintenance slower medium-acting oral preparation such as Digoxin or Gitalin or Digitoxin.

The difficult problems are represented by the 2 cases described at the beginning of this paper. There is the patient who dies dry who has become digitalis-sensitive, who may die of digitalis toxicity or more likely an irreversible electrolyte imbalance. There is the second patient who, barring the existence of mechanical obstructions, experiences increasing edema and dies wet. His therapeutic dose of the drug has equaled or passed the toxic level of the drug. He dies with a digitalis toxicity and probably in electrolyte imbalance, since we have not neglected to use diuresis which has become ineffectual.

In both of these cases, we must, like the surgeons, become more electrolyte-conscious in relation to sodium, chloride, and potassium. A complete discussion of electrolytes is beyond the scope of this paper. For suspected intracellular hypopotassemia, enteric-coated potassium chloride, Gm. 1 three times a day, may be of value. The function of the kidneys must be known when one uses potassium chloride. The patient may have an idiosyncrasy to the drug or glycoside used and may react favorably to another digitalis glycoside or to Squill or Thevetia. Concerning the dosage of the cardioactive drugs or glycosides, whether for maintenance or digitalization, we cannot be arbitrary, because an average dose indicates that 70 per cent of the patients are maintained or digitalized by dosages plus or minus 25 per cent on either side of the average dose.

Suggested programs are listed below:

Intravenous Digitalization[20]

1. Ouabain[21] 0.25 to 0.5 mg. (Parde[s])
   At the same time give 50 per cent of the estimated digitalizing dose of the glycoside of choice; by the time the Ouabain wears off, this drug will have taken effect. One then may give one-fourth at 4 to 6 hour intervals until full digitalization is achieved. Ouabain is a dangerous drug.

2. Cedilanid 0.2 mg. per cubic centimeter.
   6 cc. (1.2 mg.) immediately
   2 cc. every two hours until minor toxic symptoms appear, or the ventricular rate is controlled.
3. Digoxin (Burroughs Wellcome)
   1.0 mg. — 2 cc. initial dose.
   0.5 mg. — 1 cc. every two hours until minor toxic symptoms appear, or the ventricular rate is controlled. Caution after 2 mg. has been given.

Oral Digitalization

1. Digitoxin (Tablets 0.05 mg., 0.1 mg. and 0.2 mg.)
   0.4 mg. two times first day
   0.4 mg. on the second day
   0.1 mg. to 0.2 mg. daily maintenance.
2. Digoxin (Tablets 0.25 mg. and ampules 0.5 mg.)
   1.0 mg. two times on first day.
   0.5 mg. every 8 to 12 hours on second day.
   (Total maximum 3.0 mg. digitalizing dose)
   0.25 to 0.75 mg. daily maintenance.
3. Digitalis Folia
   0.4 Gm. two times on first day.
   0.2 Gm. on second day.
   0.1 to 0.5 Gm. maintenance.
4. Lanatoside C (Tablets 0.5 mg.; ampules 0.4 mg. and 0.8 mg.)
   7.5 mg. in 72 hours.
   1.5 mg. average maintenance.
5. Gitalin (Tablets 0.5 mg.)
   2.5 mg. initial dose.
   0.75 mg. every six hours until therapeutic effect achieved.
   0.5 mg. daily maintenance dose.

Note that within common sense and reason all these maintenance doses can be interchanged.

What are the promises for the future in digitalis therapy?

1. Digoxin.* By decreasing the alcohol content from 70 per cent to 10 per cent and by adding 40 per cent propylene glycol, this drug can be injected intravenously or intramuscularly without dilution.[22] The few trials at Bay Pines Veterans Administration Center show promise that the intramuscular injection is satisfactory and effective when rapid digitalization is indicated. No statistical reports are as yet available.[23]
2. Gitalin shows promise because of its wide therapeutic and toxic ratios.[24,25]
3. Thevetoidin has been used by Chavez[26] in cases in which there was a toxic condition or no reaction to the digitalis.
4. When a modification or intermediate product of Digoxin, namely, Acetyldigoxin, is used,[27] its activity still resembles Digoxin, but suggests the possibility of further chemical manipulation to modify the digitalis effects as with the insulins.

*Digoxin for intramuscular and intravenous use supplied by Burroughs Wellcome & Company.

Summary

1. Digitalis chemically and by action resembles the adrenocorticosteroids. By virtue of its greater specificity for the heart muscle, one may by analogy look upon Digitalis acting as a hormone equivalent to the heart.

2. Because of individual refractoriness or idiosyncrasy, the prescribing physician should not limit himself to knowing and prescribing a single cardioactive drug. Digitalis and its glycosides are few in number, and the confusion lies in the babel of proprietary drugs.

3. Digitalis therapeutically in heart failure acts on the myocardium with improvement of its electrolytic balance with reference to potassium. Diuresis affects and disturbs the electrolytic balance of both intracellular and extracellular fluids, and despite homeostasis, the action is unphysiologic.

4. Electrolyte balance should be part of the knowledge of a physician treating cardiac decompensation in this era.

5. One cannot be arbitrary in prescribing digitalis because there is a plus or minus 25 per cent deviation from the average dose, and each patient is to be judged individually.

6. When it is necessary, one may interchange a maintenance dose of digitalis when one's knowledge of dissipation and accumulation rates permits it.

7. Barring mechanical difficulties of high output cardiac failure, the digitalis group still remains the most important, if not the most physiologic, drug for the treatment of cardiac decompensation.

8. The medical treatment for cardiac decompensation remains basically unchanged, such as

Table 3. — Comparison of Cardioactive Glycosides

Drug	Rapidity of Action	Accumulation Tissue Fixation Power	Rapidity of Elimination	Ratio Therapeutic To Toxic Dose	Favorable Factors	Unfavorable Factors
Ouabain	Early 3 min. Maximum effect 30 min. to 1 hr.	Very slight +	Fast 24 hrs.	Therapeutic dose approaches toxic dose	Rapidity of action	1. Therapeutic dose close to toxic dose 2. Maintenance difficult because of fast elimination
Lanatoside C (Cedilanid)	Early 3-30 min. Maximum effect 1-5 hrs.	Slight + +	Fast 24 hrs.	Approximates Digoxin	1. Rapidity of action 2. Therapeutic to toxic dose more favorable than Ouabain	Maintenance dose difficult to establish and maintain
Digoxin	Early 3-30 min. Maximum effect 1-5 hrs.	Slight + + +	24-36 hrs.	60	1. Toxicity short duration 2. Can be given intramuscularly, intravenously and orally 3. Maintenance dose can be established orally	Patient may become undigitalized if not supervised
Gitalin	Maximum effect about 4-5 hrs.	Between Digoxin and Digitoxin + + + +	About 5 days. Less than Digitoxin	36.9	1. Wide therapeutic toxic ratio 2. Can be given intravenously and orally 3. Maintenance dose can be established orally	Cannot be used as fast-acting glycoside
Digitoxin	1-6 hrs.	Good + + + + +	Poor 1-2 wks.	58	1. High potency, complete absorption orally 2. Easy maintenance	1. Toxicity prolonged 2. Long latent period
Digilanid	Maximum effect 3 hrs. intravenously	Good + + + + +	Close to Digitoxin	Close to Digitoxin	Potency similar to whole leaf	Somewhat better than leaf, close to Digitoxin
Digitalis Leaf	Early Intravenously 30 min. Orally 2-6 hrs. Maximum effect 12 to 24 hrs.	Good, similar to Digitoxin + + + + +	Prolonged	66.5	Compares favorably with glycosides	More gastrointestinal symptoms than glycosides
Urginin		Controversial, probably greater than Ouabain	More rapid than Ouabain	Very close		
Thevetin	Intravenously 6 min. Orally 2-3 hrs.	Slight +	Intravenously 2-3 hrs	Very close		Therapeutic dose close to toxic dose

the low sodium diet, diuretics, and perhaps the ion exchange resins plus a cardioactive drug or glycoside. One, however, must maintain a consciousness of induced toxicities or electrolytic imbalances which could nullify an apparently good clinical result.

References

1. Davison, F. R.: Synopsis of Materia Medica, Toxicology, and Pharmacology for Students and Practitioners of Medicine, ed. 3, St. Louis, C. V. Mosby Company, 1944.
2. Goodman, L., and Gilman, A.: The Pharmacological Basis of Therapeutics: A Textbook of Pharmacology, Toxicology and Therapeutics for Physicians and Medical Students, New York, The Macmillan Company, 1941, p. 502.
3. Movitt, E. R.: Digitalis and Other Cardiotonic Drugs, ed. 2, New York, Oxford University Press, 1949.
4. McMichael, J.: Circulatory Failure Studied by Means of Venous Catheterization, Advances Int. Med. 2:64-101, 1947.
5. Cook, E. F., and Martin, E. W., and others, editors: Remington's Practice of Pharmacy, ed. 10, Easton, Pa., Mack Publishing Company, 1951.
6. Gutnam, A. B.: Modern Drug Encyclopedia and Therapeutic Index, ed. 5, edited by M. E. Howard, New York, Drug Publications, Inc., 1952.
7. Rothlin, E.: Some Aspects of the Differentiation of Cardioactive Glycosides, abstracted in Proc. of the Rudolph Virchow Medical Society in the City of New York, Vol. 6, New York, Brooklyn Press, Inc., 1947.
8. Herrmann, G. R.; Decherd, G. M. Jr., and McKinley, W. F.: Digitalis Poisoning, J. A. M. A. 126: 760-762 (Nov. 18) 1944; correction 126:973 (Dec. 9) 1944.
9. Mangun, G. H.; Reichle, H. S., and Myers, V. C.: Further Studies on Human Cardiac and Voluntary Muscle; Possible Implications of Changes in Creatine, Phosphorus and Potassium Content, with Special Reference to Heart Disease, Arch. Int. Med. 67:320-332 (Feb.) 1941.
10. Olson, R. E., and Schwartz, W. B.: Myocardial Metabolism in Congestive Heart Failure, Medicine 30:21-41 (Feb.) 1951.
11. Boyer, P. K., and Poindexter, C. A.: Influence of Digitalis on Electrolyte and Water Balance of Heart Muscle, Am. Heart J. 20:586-591 (Nov.) 1940.
12. Clarke, N. E., and Mosher, R. E.: Water and Electrolyte Content of Human Heart in Congestive Heart Failure With and Without Digitalization, Circulation 5:907-914 (June) 1952.
13. Cohen, B. M.: Digitalis Poisoning and Its Treatment, New England J. Med. 246:225-230 (Feb. 7); 254-259 (Feb. 14) 1952.
14. Stroud, W. D., editor: Diagnosis and Treatment of Cardiovascular Disease, ed. 4, Vol. 1., Philadelphia, F. A. Davis Company, 1950.
15. Zwemer, R. L., and Lowenstein, B. E.: Cortin-Like Effects of Steroid Glycosides on Potassium, Science 91:75-76 (Jan. 19) 1940.
16. Lesser, G. T.; Dunning, M. F.; Epstein, F. H., and Berger, E. Y.: Mercurial Diuresis in Edematous Individuals, Circulation 5:85-90 (Jan.) 1952.
17. Lown, B.; Salzberg, H.; Enselberg, C. D., and Weston, R. E.: Interrelation Between Potassium Metabolism and Digitalis Toxicity in Heart Failure, Proc. Soc. Exper. Biol. & Med. 76:797-801 (April) 1951.
18. Burwell, W. B., and Hendrix, J. P.: Digitalis Poisoning, Am. J. Med. 8:640-657 (May) 1950.
19. American Medical Association: New and Nonofficial Remedies, Philadelphia, J. B. Lippincott Company, 1952.
20. Conn, H. F., editor: Current Therapy, Philadelphia, W. B. Saunders Company, 1953.
21. Gold, H., and others, editors: Cornell Conferences on Therapy, Vol. I, Digitalis Versus Digitoxin, New York, The Macmillan Company, 1946.
22. Communication from Burroughs Wellcome & Company.
23. Personal communication from Dexter, M., Veterans Administration Center, Bay Pines.
24. Batterman, R. C., and others: Studies with Gitalin (Amorphous) For Treatment of Patients with Congestive Heart Failure, Am. Heart J. 42:292-301 (Aug.) 1951.
25. Batterman, R. C.; DeGraff, A. C., and Rose, O.: Therapeutic Range of Gitalin (Amorphous) Compared with Other Digitalis Preparations, Circulation 5:201-207 (Feb.) 1952.
26. Chavez, J.; Mendez, R., and Chait, L. O.: Study of Digitalis-like Action of Theyetoidin in Man, Circulation 5:12-19 (Jan.) 1952.
27. Enselberg, C. D.; Brodoff, B. N., and Griboff, S. I.: Action of New Oral Preparation of Digitalis, Acetyldigoxin, Am. Heart J. 45: 909-913 (June) 1953.

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New Concepts in Familial Hemolytic Syndromes, With Particular Reference to Filter Paper Electrophoresis

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PENSACOLA

Discovery of two new types of abnormal hemoglobin inherited according to mendelian principles has clarified considerably the problem of "atypical" forms of inherited hemolytic syndromes.

According to the recently adopted standard nomenclature, normal hemoglobin, that is, the hemoglobin found in the erythrocytes of most adults regardless of race, has been termed type A. This hemoglobin migrates most rapidly on filter paper electrophoresis and is denatured by strong alkali solutions according to the method of Singer, Chernoff, and Singer.[1] Its occurrence in combination with abnormal hemoglobins will be described.

Type F, or fetal hemoglobin, constitutes from 55 to 85 per cent of the hemoglobin in the erythrocytes of normal newborn infants.[1] Following birth, the percentage of F hemoglobin decreases, with a reciprocal rise in that of type A hemoglobin. By 16 months of age, less than 2 per cent of F hemoglobin remains in the blood of most infants. In an occasional apparently normal person, small amounts of fetal hemoglobin will persist throughout adult life. Its site of origin and significance remain conjectural at present.

F hemoglobin is identified by its resistance to alkali denaturation.[2] It migrates only a trifle more slowly than A hemoglobin on filter paper electrophoresis, so that appreciable amounts must be present to allow identification by this method.

A type of hemoglobin indistinguishable from F hemoglobin is the predominant abnormal hemoglobin in patients with thalassemia (Cooley's

or Mediterranean anemia), the remaining hemoglobin consisting of the A variety. The percentage of F, or F-like, hemoglobin in such patients may range from less than 2 per cent to 70 per cent.[1] There is no consistent relationship between the amount of F hemoglobin present and the clinical degree of thalassemia, that is, ranging from major to minor. Hemoglobin F also is found in patients with sickle cell disease, but not in those with the sickling trait. Small amounts may be present in patients with hereditary spherocytosis, as well as in other situations to be described.

S hemoglobin is responsible for the sickling phenomenon. In filter paper electrophoresis, S hemoglobin moves more slowly than types A and F. It is not alkali resistant, but forms tactoids as described by Harris.[2] In patients with sickle cell disease, it is the predominant hemoglobin, occurring with varying amounts of F hemoglobin only. The erythrocytes of persons with the sickling trait contain S and A hemoglobins in varying proportions.

C hemoglobin was discovered through electrophoretic analysis of hemoglobin solutions.[3] It is the most slowly migrating of the hemoglobins, and is denatured by alkali. Patients with the C trait have in their erythrocytes A hemoglobin as well as C hemoglobin. Four patients with homozygous C hemoglobin, analagous to those with homozygous S (sickle cell disease), have been discovered to date.[4,5] No conclusions as to a characteristic clinical course can be drawn as yet.

When the genes of S hemoglobin and C hemoglobin unite in the same person, the resultant syndrome has been termed sickle cell hemoglobin C disease.[6,7] Patients with this condition comprise the majority of those previously referred to as having "atypical sickle cell disease." These patients' blood smears show a great increase in the number of target cells, as well as relatively small numbers of sickled cells. They may or may not have a mild chronic anemia and splenomegaly. They are subject to hemolytic crises, usually milder than those of patients with sickle cell disease. By the appropriate tests, from 2 to 22 per cent of F hemoglobin, and varying relative percentages of S and C hemoglobin, will be identified.

When one parent has thalassemia and the other sickle cell trait, some of their children will inherit both abnormalities. The resultant syndrome has been termed microdrepanocytic disease, after the characteristic cell types, that is, the microcyte of thalassemia and the drepanocyte, or sickle cell. The disease is characterized hematologically by hypochromic anemia, sicklemia, decreased red cell fragility in hypotonic saline, microcytosis, ovalocytosis, anisocytosis, poikilocytosis, and target cells. By electrophoresis and alkali denaturation, the hemoglobin is found to be a mixture of types A, S, and F.[8] Clinically, these patients have mild to moderate hepatomegaly and splenomegaly, with a history of recurrent fever and jaundice indicating mild hemolytic episodes.

A fourth abnormal hemoglobin has been discovered in two families with hereditary hemolytic anemia and has been designated D hemoglobin. This hemoglobin migrates identically with S hemoglobin on filter paper electrophoresis and is separated from it according to differential solubilities in phosphate buffer solutions.[9]

Clinical Application

Our interest in this field has centered around the clinical application of filter paper electrophoresis to the problem of chronic anemias and hemolytic diseases, particularly in the Negro race. To date, C hemoglobin has been found only in this ethnic group. S hemoglobin is restricted largely to Negroes and peoples in whom an admixture of Negro blood is probable. Thalassemia has been found in white and Negro families.

The filter paper electrophoretic apparatus and procedure used was that of Slater and Kunkel,[10] as modified by Smith and Conley.[7] In the interest of economy, carbon electrodes were used and found to be satisfactory.

Figure 1 serves both to illustrate the results obtained and to depict graphically two characteristic clinical situations.

Figure 1B is a composite run of the hemoglobin solutions prepared from the blood of all members of one Negro family. At the start, each hemoglobin comprised a single spot at the left of the illustration. After three and one-half hours of electrophoresis, separation was well established. The A hemoglobin had migrated most rapidly to the right, forming the farthermost line of spots. The S hemoglobin had moved more slowly, forming the second line of spots, while the C hemoglobin had migrated most slowly, lining up just to the right of the line of origin.

It is seen that the father, P, carries both S and A hemoglobin and bears, therefore, the sickle cell trait. The mother, M, has C and A hemoglobins and carries the C hemoglobin trait.

Only one child, ♂ 1, has inherited the normal hemoglobin gene from each parent, showing only A hemoglobin. Two children, ♀ 2 and ♀ 3 have gained the C trait from the mother and normal hemoglobin from the father and are themselves carriers of the C trait.

Three children, ♀ 4, ♂ 5, and ♂ 6, received only the gene of the abnormal hemoglobin from each parent, S and C, and therefore have sickle cell hemoglobin C disease. Of these, the oldest girl, ♀ 4, has suffered two fairly severe hemolytic crises. The second child, ♂ 5, has had one mild crisis, while the third, ♂ 6, has remained clinically well to date.

Figure 1A displays as controls a known normal hemoglobin at the top, and the hemoglobin from known sickle cell hemoglobin C disease and known C trait at the bottom.

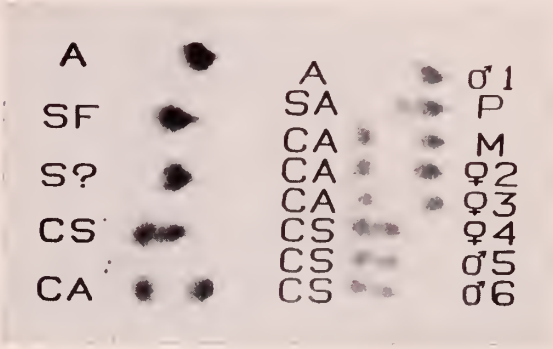


Fig. 1. — Typical patterns obtained by the filter paper electrophoresis of hemoglobin solutions (see text).

Just below the normal hemoglobin is the sample from a 13 year old Negro boy with clinically typical sickle cell disease. As can be seen, practically all of the hemoglobin lines up in the S position. The triangular leading element is probably F hemoglobin.

The spot in the middle position is hemoglobin from a 30 year old patient of mixed lineage with chronic hemolytic disease, who has had several severe hemolytic crises. Rapid sickle cell testing produces only about 5 per cent sickle cells, while routine smears show 60 to 70 per cent target cells. Alkali denaturation studies have shown only 16 per cent F hemoglobin. Further studies on this patient proved the presence of microdrepanocytic disease. A survey of his family will be the subject of a separate report.

We would like to emphasize the fact that these examinations by filter paper electrophoresis are being performed in a clinical laboratory and at the clinical level. Following the initial runs to establish experience and iron out the technical details, the procedure has been applied only to patients whose history, physical examination and routine blood studies have indicated its possible helpfulness, and to their families.

Hemoglobin solutions from 83 different patients have been examined to date, including 43 Negroes. Of these latter, 18 have been normal, 4 have had sickle cell disease, 8 have shown the sick-

Table 1. — Summary of Abnormal Hemoglobins*

Type of Hemoglobin	Clinical Condition	Typical Erythrocyte	Method of Identification
A	Normal adults Spherocytosis	Normal Spherocyte	Filter paper electrophoresis, denatured by alkali
F	Thalassemia Normal infants	Microcyte Normal	Resistant to alkali denaturation (filter paper electrophoresis)
S	Sickle cell disease Sickle cell trait	Sickle cell Sickle cell	Rapid sickling test with SMB† (filter paper electrophoresis)
C	Hemoglobin C trait	Target cell	Filter paper electrophoresis
D	Hemoglobin D disease		Solubility in phosphate buffers (filter paper electrophoresis)
S + C	Sickle cell hemoglobin C disease	Sickle cell Target cell	Filter paper electrophoresis
S + F	Microdrepanocytic disease	Microcyte Sickle cell	Stained smear, sickling test (resists alkali denaturation, filter paper electrophoresis)

*Summary of abnormal hemoglobins by type, clinical conditions in which they are of importance, predominating erythrocyte morphology in stained blood smear, and methods of identification. Labratory procedures which aid in identification but are not the methods of choice are enclosed in parentheses. Stained smears obviously are valuable in each instance, and are only particularly so when mentioned.

†Sodium metabisulfite (Lilly).

ling trait, 5 are carrying the C trait, 3 have been identified as having sickle cell hemoglobin C disease, 3 have thalassemia minor, and 2 show microdrepanocytic disease.

Various practical applications have arisen or are anticipated. Foreknowledge of the existence of sickle cell hemoglobin C disease in 2 patients has facilitated the differentiation of a mild hemolytic crisis from an infectious process. As mentioned, several "atypical sicklers" have been identified as SC bearers. Prognostic implications in the fields of pediatrics, and perhaps obstetrics, are obvious.

Summary

Five types of hemoglobin have been discovered to date: A or normal hemoglobin, F or fetal hemoglobin, S or sickle cell hemoglobin, and C and D hemoglobins (table 1).

Various hematologic and clinical situations, as described, arise from the inheritance of these types in various combinations.

Filter paper electrophoresis, as adapted for the clinical laboratory, is a practical method for identifying the combinations of A, F, S, and C hemoglobins in the elucidation of problems in patients with mild hemolytic syndromes.

References

1. Singer, K.; Chernoff, A. I., and Singer, L.: Studies on Abnormal Hemoglobin; Their Demonstration in Sickle Cell Anemia and Other Hematologic Disorders by Means of Alkali Denaturation, Blood 6:413-428 (May) 1951; ibid., 7:1216-1226 (Dec.) 1952.
2. Harris, J. W.: Studies on Destruction of Red Blood Cells; Molecular Orientation in Sickle Cell Hemoglobin Solutions, Proc. Soc. Exper. Biol. & Med. 75:197-201 (Oct.) 1950.
3. Itano, H. A., and Neel, J. V.: A New Inherited Abnormality of Human Hemoglobin, Proc. Nat. Acad. Sci. 36:613-617 (Nov.) 1950.
4. Spaet, T. H.; Alway, R. H., and Ward, G.: Homozygous Type "C" Hemoglobin, Pediatrics 2:483-490 (Nov.) 1953.
5. Unpublished reports.
6. Kaplan, E.; Zuelzer, W. W., and Neel, J. V.: A New Inherited Abnormality of Hemoglobin and Its Interaction with Sickle Cell Hemoglobin, Blood 6:1240-1249 (Dec.) 1951.
7. Smith, E. W., and Conley, C. L.: Filter Paper Electrophoresis of Human Hemoglobins with Special Reference to Incidence and Clinical Significance of Hemoglobin C, Bull. Johns Hopkins Hosp. 93:94-106 (Aug.) 1953.
8. Neel, J. V.; Itano, H. A., and Laurence, J. S.: Two Cases of Sickle Cell Disease Presumably Due to the Combination of the Genes for Thalassemia and Sickle Cell Hemoglobin, Blood 8:434-443 (May) 1953.
9. Itano, H. A.: A Third Abnormal Hemoglobin Associated with Hereditary Hemolytic Anemia, Proc. Nat. Acad. Sc. 37:775-784, 1951.
10. Slater, R. J., and Kunkel, H. G.: Filter Paper Electrophoresis with Special Reference to Urinary Proteins, J. Lab. & Clin. Med. 41:619-631 (April) 1953.

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Volume XLI
Number 1

DeQuervain's Disease
A Survey of Forty-Seven Cases

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In 1895, an unusual tendon sheath disease, involving two tendons at the base of the thumb, was first described by Fritz DeQuervain, while working as an assistant at Kocher's Clinic in Berne, Switzerland. This disease has been known as DeQuervain's disease and is more specifically a thickened, fibrotic constriction of the common sheath that surrounds the abductor pollicis longus and the extensor pollicis brevis tendons as they course over the groove in the styloid process of the radius (figs. 1 and 2).

Most surgical texts fail to mention the existence of this syndrome,[1] although it is not a rare condition and must be included in the differential diagnosis of those conditions that cause prolonged pain or disability in the wrist, thumb or hand. The purpose of this paper is to review the clinical highlights of DeQuervain's disease and to report an analysis of 47 relatively recent cases. In most of these cases the patients were operated upon by staff members of the Carney Hospital, South Boston, Mass., and the Jackson Memorial Hospital, Miami, and by us.

DeQuervain's disease may be so disabling that the patients may be unable to continue with their former occupations. The affected person refuses to use the involved hand or thumb for any reason whatsoever. Temporary relief may be given by means of splinting and physiotherapy, but the only treatment of permanent value is the operative division and partial excision of the involved tendon sheath so that the imprisoned tendons may once again function unembarrassed.

Aitken[1] pointed out that this disease has the greatest incidence among middle-aged women and occurs only rarely in men. He attributed this difference in incidence to the great increase in the employment of women in occupations that expose their working hand to the peculiar type of repeated trauma necessary to cause the disease. The same observer, however, concluded that this cannot completely explain the increased incidence in women and that other causes must be sought. Others[3,7] believe that the greater incidence in women is due to the greater joint angulation in the female than in the male.

We have observed from the study of this series of cases that the patient who ultimately comes to operation has been treated for many weeks or months with either physiotherapy, splinting or a plaster cast. Such treatment usually continues for a long period of time and terminates only when the exact condition is recognized or the patient demands a change in treatment.

Etiology

If one carefully observes the anatomic relations of the two tendons involved, he will note that they lie in a more superficial position than the other tendons and therefore are more liable to external trauma than the other tendons. Furthermore, as the short extensor and long abductor tendons merge together from the osteofibrous canal, they separate rather sharply. The abductor pollicis longus inserts into the lateral aspect of the base of the first metacarpal and the extensor pollicis brevis inserts into the dorsum of the base of the proximal phalanx of the thumb (fig. 2). Because of this sudden separation of the tendons upon their exit from the sheath compartment, considerable tension is produced within the sheath when the thumb is extended and abducted. This tension, exerted repeatedly over a long period of time, can readily be the cause of the thickening and consequent constriction of the fibrous sheath. Lipscomb[10] was of the opinion that those occupations that necessitate repeated abduction of the thumb under the stress of grasping posi-

tions associated with abduction of the thumb and ulnar deviation of the wrist, such as typing, knitting, golfing, flycasting, piano playing, and work on grinding and buffing machines, cause this condition.

which the various extensor tendons are contained (fig. 1). The first canal or most lateral osteofibrous canal corresponds with the groove on the outer side of the lower end of the radius and contains the tendons of the abductor pollicis longus

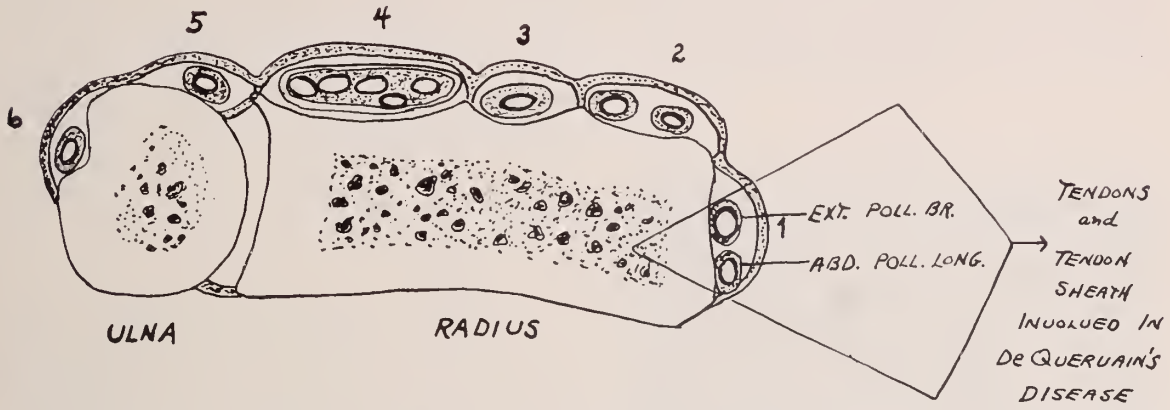


Fig 1.— The six osteofibrous compartments on the dorsal aspects of the lower ends of the radius and ulna are shown. The various extensor tendons are contained within these canals. The first compartment contains the tendons enumerated and is the area involved in DeQuervain's disease.

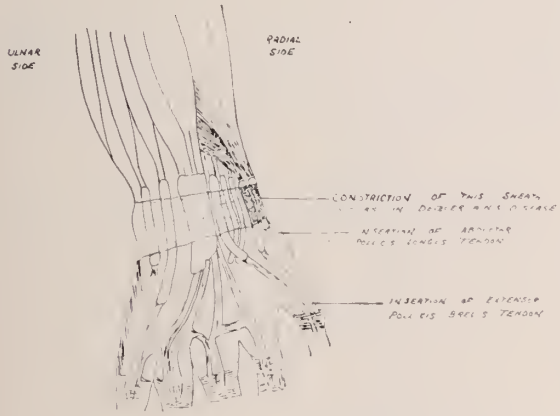


Fig. 2.— The involved tendon sheath and tendons are shown. The insertions of the tendons of the abductor pollicis longus and the extensor pollicis brevis are indicated.

Anatomy

Dr. Bryan Keon-Cohen[8] of Melbourne, Australia, described well the anatomy of this area of the hand as follows: "The extensor retinaculum, a thickening of the deep fascia, bridges the grooves on the dorsal aspects of the lower ends of the radius and ulna. This retinaculum or dorsal carpal ligament is attached by deep processes to the ridges between the radius and ulna, converting them into six osteo-fibrous canals within and the extensor pollicis brevis. The abductor tendon is anterior to the extensor tendon, and they are closely applied to one another until they emerge from the compartment sheath. The dorsal cutaneous branch of the radial nerve pierces the deep fascia just proximal to the wrist joint. Its three branches, on their way to supply the thumb and the radial half of the index fingers, pass superficial to the first fibro-osseous canal." This latter anatomic fact is important to remember because the nerve should be retracted during the operative procedure.

Pathology

At operation, one observes that the fibrous sheath, which is about 1 to 2 cm. in length, is unusually thickened (fig. 3). It may be 0.3 cm. thick and may have the consistency of cartilage. The characteristic reaction of all synovial membranes to irritation is exudation, which, in time leads to a deposition of fibrin in the sheath. When the sheath is opened, the lining synovial membrane is found to be markedly injected. It is not at all unusual for the synovial membrane to be bound down to the tendons by dense adhesions that can be removed only by sharp dissection. The pathologic changes vary from serous effusion within the sheath, with edema and round cell infiltration of the sheath wall, to great thickening of dense, fibrous layers with hyaline degeneration.

Both the tendon and the tendon sheath may have lost the normal pearly luster or sheen, and the epitenon may be discolored, due to the inflammatory reaction which ranges from slight edema to congestion of great degree. One may observe flattening and thinning out of the tendons at the constricting area of the tendon sheath. The tendons on each side of the constricted area not infrequently appear to be swollen.



Fig. 3.—Scissors underneath markedly thickened fibrous sheath prior to incision and excision. Note cutaneous branch of radial nerve retracted out of wound. The wound is dry because of pneumatic cuff being placed about upper arm.

Microscopically, one observes an increase in the fibrous and vascular tissues. There appear to be varying stages of lymphocytic and fibroblastic infiltration depending on the duration of the disease. Calcium deposits may occasionally be seen within the sheath. Finkelstein[6] reproduced this condition experimentally in rabbits by mechanical and chemical means. Stein, Ramsey and Key[16] believed that the essential lesion in DeQuervain's disease is "degeneration followed by proliferation and increased vascularity in the roof of the fibrous and bony canal over the styloid process of the radius." Whether the proliferative changes or the degenerative changes are primary is not known, but it seems most likely that the primary change is degeneration. The secondary increase in vascularity in the production of fibroblasts results in the thickening of the fibrous roof, and in this manner causes a constriction of the lumen. This results in constant pressure being exerted on the tendon surfaces within the canal. A vicious cycle of thickening and pressure takes place that results in further thickening of the sheath and more constriction of the tendons.

Symptomatology and Examination

The classical picture first described by DeQuervain consists of pain radiating from the radial styloid process down the thumb and up the forearm, slight tumefaction in the region of the tendon sheath, pain on movement of the thumb and wrist, and inability to grasp objects firmly. Severe pain is produced by sudden, active abduction of the thumb. Any grasping motion, such as the use of a forceps or a hammer is particularly painful. This disease occurs rarely in persons under 25 years of age.

On examination one may sometimes, but not always, observe a distinct swelling over the radial styloid process. Direct pressure in this region produces exquisite tenderness. The Finkelstein test[7] (fig. 4) is probably "the most pathognomonic objective sign." The thumb is placed in the palm of the hand, the fingers are flexed firmly over it, and the hand is then placed in ulnar flexion. Severe pain results if DeQuervain's disease is present. If the thumb is released, flexion of the fingers with ulnar flexion of the hand is then not painful.

Differential Diagnosis

The differential diagnosis in DeQuervain's disease must include:

1. Tuberculous tenosynovitis
2. Tuberculous osteitis
3. Gout
4. Gonorrhea
5. Syphilis
6. Neuritis
7. Rheumatic diseases
8. Sprain of the wrist
9. Ganglion of the wrist
10. Fractured scaphoid bone
11. Bursitis
12. Hypertrophic arthritis
13. Cyst of the navicular bone
14. Periostitis of the radial styloid process

In tuberculous tenosynovitis, there is usually considerable bulging both below and above the dorsal carpal ligament so as to give an hourglass appearance. Rice bodies must be looked for and may be palpated. Tuberculous tenosynovitis is usually a secondary rather than a primary condition and most frequently occurs as an extension

from a focus of infection in an adjacent bone or joint. Tuberculous osteitis can usually be demonstrated by roentgenogram. Gout, gonorrhea and syphilis can be diagnosed by means of the history, blood studies and roentgen studies. The rheumatic diseases rarely affect one joint only, and a thorough physical examination is of help in this instance. Neurologic examination aids in the diagnosis of neuritis. A sprain affects more than one localized area. Hypertrophic arthritis and fractures are diagnosed roentgenologically as are also cysts of the navicular bone. A ganglion presents a small, firm, rather fluctuant area that is well circumscribed and localized in contradistinction to the findings of DeQuervain's disease. Periostitis, when present, will also be observed on the roentgen examination.



Fig. 4.—Finkelstein Test. The fingers are flexed firmly over the thumb, which is placed in the palm of the hand. Ulnar flexion produces acute pain over the radial styloid process.

Treatment

We believe that general anesthesia is the anesthesia of choice when performing the operative procedure. It has a definite advantage over local anesthesia inasmuch as the tissues are not distorted and a tourniquet can be applied without discomfort to the patient. A pneumatic type of tourniquet is applied around the upper arm at 300 mm. pressure in order to maintain a dry operative field. The hand and wrist are draped with a sterile stockinette, following the usual preparation of the extremity with ether and Zephiran. The stockinette drape is divided over the involved area, and, in this manner, adequate sterility of the operative area is maintained. In order to avoid cutting the dorsal branch of the radial nerve, it is advisable to make a longitudinal incision and, at the same time, secure a wider exposure so that a more thorough operation may be performed. The mid point of the incision is made over the tip of the styloid process, and the thickened tendon sheath is immediately brought into view (fig. 3).

The thickened area of the tendon sheath is then divided with the scissors or scalpel, and the involved tendons are readily recognized. This thickened sheath is then mobilized around the tendons and as much as possible of the sheath is excised, thus completely baring the involved tendons (fig. 5). This latter maneuver prevents the possibility of a recurrence and any further disability resulting from a readherence of the divided ends of the sheath. As soon as it is freed, the tendon will resume its normal shape. A simple approximation of the skin without subcutaneous suturing completes the operation. A firm gauze dressing reinforced with an Ace bandage is then applied. Splinting in any manner is avoided, and early active motion is instituted on the day following surgery. Complete and immediate relief of pain is the proof of a successful surgical procedure.

In all fairness to those authors who have reported a few cases with recovery under conservative treatment, we would like to emphasize that in those cases in which the sheath has become markedly thickened, no alternative except division and excision of the sheath would be of therapeutic value.



Fig. 5.—Thickened sheath has been excised and the involved tendons completely bared. Note at upper pole of photograph the extensor pollicis longus tendon.

Analysis of Cases

Of the 47 cases that we have studied, in 40 the patients have been operated upon within the past five years. Out of the 47 cases 36, or 76.5 per cent, occurred in women. The ratio of women to men was 3.27 to 1. The average age was 41.6 years with a maximum of 64 and a minimum of 23 years. The occupations of these patients were varied; there were 2 switchboard operators, 5 machine operators, 2 seamstresses, 3 cutters, 3 automobile mechanics and 7 housewives.

The duration of the symptoms prior to surgery was extremely long with a maximum of seven years and an average time of six and a half months.

The results were almost uniformly excellent, and all the patients claimed immediate relief of discomfort on the day after surgery. There was 1 case listed as "no improvement," in which failure to obtain relief was attributed to a coexistent, severe arthritic condition of the wrist.

Summary

The etiology, surgical anatomy, pathology and treatment of DeQuervain's disease are discussed.

DeQuervain's disease, although frequently unrecognized, is a disabling condition which is readily remedied by surgery. A technic is demonstrated that is simple to follow and avoids injury of the cutaneous branch of the radial nerve.

The incidence of the disease is greater in women, and this condition should be considered in the differential diagnosis of persistent pain at the base of the thumb in the region of the radial styloid process.

Delay in surgery means continued severe pain and disability and the loss of many man hours of work.

A series of 47 cases of DeQuervain's disease is analyzed, and the results are summarized.

References

1. Aitken, A. P.: Stenosing Tendovaginitis at Radial Styloid Process (DeQuervain's Disease), New England J. Med. 232:105-107 (Jan. 25) 1945.
2. Baker, L. D., and Shutkin, N. M.: Peritendinitis of Extensor Pollicis Brevis and Abductor Pollicis Longus Tendons—DeQuervain's Disease, North Carolina M. J. 8:346-348 (June) 1947.
3. Bunnell, Sterling: Surgery of the Hand, Philadelphia, J. B. Lippincott Company, 1944.
4. Cotton, F. J., Morrison, G. M., and Bradford, C. H.: DeQuervain's Disease; Radial Styloid Tendovaginitis, New England J. Med. 219: 120-123 (July 28) 1938.
5. Edwards, E. G.: DeQuervain's Stenosing Teno-vaginitis at Radial Styloid Process, South. Surgeon 16:1081-1087 (Nov.) 1950.
6. Finkelstein, H.: Stenosing Tendovaginitis at Radial Styloid Process, J. Bone & Joint Surg. 12:509-540 (July) 1930.
7. Haggart, G. E., and Winter, E. F.: De Quervain's Disease; Stenosing Tendovaginitis over Radial Styloid, S. Clin. North America 28:817-820 (June) 1948.
8. Keon-Cohen, B.: DeQuervain's Disease, J. Bone & Joint Surg. 33:96-99 (Feb.) 1951.
9. Keyes, H. B.: Stenosing Tendovaginitis at Radial Styloid Process, Ann. Surg. 107:602-606 (April) 1938.
10. Lipscomb, P. R.: Chronic Nonspecific Tenosynovitis and Peritendinitis, S. Clin. North America 24:780-797 (Aug.) 1944.
11. McDonald, J. E., and Stuart, F. A.: Stenosing Tendovaginitis at Radial Process, J. Bone & Joint Surg. 21:1035 (Oct.) 1939.
12. Miller, L. F.: Stenosing Tendovaginitis; Survey of Findings and Treatment in 49 Cases, Indust. Medicine 19:465-467 (Oct.) 1950.
13. Patterson, D. C., and Jones, E. K.: DeQuervain's Disease; Stenosing Tendovaginitis at Radial Styloid, Am. J. Surg. 67:296-301 (Feb.) 1945.
14. Potter, P. C.: Stenosing Tendovaginitis at Radial Styloid (DeQuervain's Disease), Ann. Surg. 117:290-296 (Feb.) 1943.
15. Schneider, C. C.: Stenosing Fibrous Tendovaginitis over Radial Styloid (DeQuervain), Surg., Gynec. & Obst. 46:846-850 (June) 1928.
16. Stein, A. H. Jr.; Ramsey, R. H., and Key, J. A.: Stenosing Tendovaginitis at Radial Styloid Process (DeQuervain's Disease), A. M. A. Arch. Surg. 63:216-228 (Aug.) 1951.
17. Stern, H. C.: Stenosing Tendovaginitis, Am. J. Surg. 3:77 (July) 1927.
18. Wood, C. F.: Stenosing Tendovaginitis at Radial Styloid Process, South. Surgeon 10:105-110 (Feb.) 1941.

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ABSTRACTS OF MEDICAL ARTICLES

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 1018, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

The Journal of the American Medical Association is limiting its Current Medical Literature section. Thus, our main source of information on articles written by our members has been greatly curtailed.

Cytology: An Aid in the Early Diagnosis of Cancer of the Cervix. By R. B. Chrisman Jr., M.D. Am. Surgeon 19:650-653 (July) 1953.

Describing cytology as a keystone for the detection of cervical cancer which may not be apparent clinically, this author relates that for some 20 months he had taken cervical scrapings from most of his gynecologic patients. During that time he had learned that positive cancer cells may be found (1) in the cervix showing clinical suspicion of cancer; (2) in the eroded or inflammatory cervix where there is little or no suspicion of cancer, and (3) in the clinically normal-appearing cervix. In the latter two groups cytodiagnosis offers its most important contribution. He emphasizes that cancer of the cervix is a young woman's cancer, a fact which considerably magnifies its importance, and presents evidence to show the advantages of taking cervical smears for cytologic study. He then describes the technic of obtaining the smears.

In addition to declaring cytology a valuable aid in the early diagnosis of cancer of the cervix, he concludes with these observations: Clinically recognizable cancer of the cervix or definite clinical suspicion usually represents an advanced stage of the neoplasm. Many leading physicians recommend routine cervical cell scrapings on all patients. The physician's office is the logical cancer detection center. The cervical cell scraping is a rapid, painless, inexpensive procedure and can be repeated as often as necessary. Biopsy confirmation of all positive cytologic cases is imperative, preferably by the ring biopsy technic.

Forgive Us Our Debts. By Walter C. Jones, M.D. South. M. J. 46:1147-1151 (Dec.) 1953.

In his President's Address before the Southern Medical Association at its forty-seventh annual meeting, Dr. Jones declares that it is time for the medical profession to review its heritage and earnestly adjust its errors of the present in order that medicine may continue its esteemed position in the future. He reviews its majestic parade of progress across the years, which has made physicians the recipients of countless beneficent gifts and thereby equally obligates them to carry on in the best tradition of the past.

In taking inventory of today's assets and debits, he finds the medical world centered in America, where educational leaders have been foresighted and free enterprise has enabled the individual to forge ahead. For the premedical student he prefers not to shorten the training period, favors more stress on philosophy, economics, psychology and logic, advises more extensive training in the use of the English language, and encourages substitution of Spanish as a modern language, when desired, in all premedical courses. Observing that no other profession is so hard to enter as medicine, he regards the spirit of the student as evidenced by his moral stamina and genuine desire to dedicate his life to the service of sick mankind as the essential guide in the selection of the future physician who will be ethical and nonmercenary with a willingness to serve humanity.

Dr. Jones sees in the number, the diversity and the very value of modern sciences a threat

to the intellectual art of medicine. In the multiplicity of theories and the application of modern science, the patient is forgotten. Progress lies in the teaching centers finding ways to deal with the sick patient as a whole. The teaching of clinical medicine, he fears, may be overshadowed by research projects. He sees in the physician-patient principle of teaching an experiment deserving careful watching, for it keeps the patient in focus as the student's chief concern.

Deploring the present segmentation of hospital training, he makes a strong plea that help be given graduate hospitals in their residency training programs from some central group. He also sees a good omen in the trend away from overemphasis on specialization to mounting interest in general practice.

With the personal touch still a vital part of good medical practice, public relations is fundamentally not group relationship alone, but even more the individual relationship of the physician with his patient and family. If such a program should be adopted as an individual campaign, Dr. Jones is convinced that the hazards of statism could never win over the advantages of free enterprise. Too, he would have the physician pursue civic and political activities in keeping with his rights and duties of citizenship.

With the poet Milton he says, " 'Awake, arise, or be forever fallen.' So let us earnestly and unselfishly struggle forward for preservation and advancement of medicine! In a suppliant attitude recognizing our mistakes may we have as our prayer, 'Forgive us our debts.' "

The Beloved Physician. By Frank G. Slaughter, M.D. South. M. J. 46:1223-1226 (Dec.) 1953.

Most physicians are beloved by the people they serve and find therein one of the greatest rewards of their calling. In this discourse, however, Dr. Slaughter singles out a particular "beloved physician" of the long ago, so designated by his most famous patient, St. Paul, in tribute to Luke, his friend, personal physician and devoted companion. Florida's distinguished surgeon-author is peculiarly fitted to pay tribute to this towering figure of an early day who was renowned not alone as a physician but also as a man of letters, for in recounting the birth of Jesus he set down in his Gospel the best known and most tenderly beautiful story the world has ever known. In the course of his research for "The Road to Bithynia," a life of St. Luke in novel form which was published in 1951, Dr. Slaughter for over two years lived daily with Luke and his companions. He came to know intimately every facet of their lives, including their thoughts, which had been set down in writing. This experience enabled him to bring alive in the pages of his unique book this early practitioner of the healing art to whom the world across succeeding centuries is everlastingly indebted. It also dispelled for him any lingering doubt that the answers to most of today's troubles, both in medicine and in everyday life, lie in restudying the past.

In this address before the Southern Medical Association Dr. Slaughter portrays Luke as exemplifying the ideal physician. He lived in times of tension, fear, national and international unrest, and personal uncertainty and insecurity amazingly like our own times. To the problems which were just as perplexing then to man as they are today, this physician-author of Biblical times found the solution in the life and teachings of Jesus Christ and the dedicated men who carried on His work after the Crucifixion. Furthermore, he recorded the answer for the world to read. In language more beautiful and effective than any modern writer has been able to command, he set down the way to peace and individual security through the teachings of the Man of Nazareth. "If any man will come after me, let him say 'NO' to self," was a teaching of the Master fully appreciated by Luke, for the welfare of others always comes first with the physician dedicated to his calling. Self denial and service to others are as much a part of the training and work of a doctor as the tools he uses in the operating room, the medicine he prescribes in his office. Again and again in his writings, Luke also held aloft as a flaming torch the simple concept of individual dignity and importance in the eyes of God. Withal, he made it clear that such simple principles of human conduct are timeless, as effective now as they were nineteen hundred years ago.

Dr. Slaughter sees it as no accident or coincidence that the medical profession today has been the strongest bulwark against trends calculated to lead to the downfall of true democracy and the loss of individual dignity and freedom

which are its essence. History, he avers, will yet honor medicine for daring in times like these to be stubborn about individual freedom.

There is record that "Luke . . . having neither wife nor children, . . . died in Bithynia at the age of seventy-four, filled with the Holy Spirit." Long and hard was the winding road of life that led him at last to that earthly Shangri-La for which he doubtless yearned across the years. Much earlier, however, he had found "the real Bithynia of the spirit in the teachings of Jesus, where all of us may find them today, if we but read the words of 'the beloved physician.'"

The Successful State Medical Journal. By Shaler Richardson, M.D. J. M. A. Georgia 42:427-429 (Sept.) 1953.

In this timely article the Editor of the Journal of the Florida Medical Association shares the fruits of his editorial experience over a quarter of a century of medical progress, including broad advances in medical journalism. The paramount thought is that the journal of any state medical association can be only as good as the members make it. It is theirs not alone from the standpoint of ownership but also from the standpoint of contributions. The quality of its scientific articles is a gauge of professional progress which, above all, determines its rating as a medical periodical.

The editorial section reflects matters of moment to the members. The abstract department gives them recognition in their own journal for their articles published in out-of-state journals. From President's Page to news items and the several special sections, the various features reflect the activities and interests of the members. Every member, therefore, can make some constructive contribution to his journal, if only a news item, and should take perennial interest in doing so.

In discussing finances, Dr. Richardson pointed the way to economy and explained the handling of advertising. The better the journal, of course, the more appeal it has to advertisers. In the publication of a successful medical journal this phase, as do all others, leads right back to the grass roots of individual members, their interests and their participation. To say that a state medical journal is as good as its editors is true so far as it goes, but it is also true that they can make it only as good as is the material provided by the members.

Hemoptysis. By G. Dekle Taylor, M.D. South. M. J. 46:1174-1180 (Dec.) 1953.

The diagnosis and management of hemoptysis are reviewed from the standpoint of the otolaryngologist. Frequently he is the first physician to see the patient with this symptom, and it is his responsibility to establish a diagnosis and refer the patient to the internist or thoracic surgeon if necessary. A thorough evaluation of many cases of hemoptysis requires adeptness on the part of the otolaryngologist in anterior and posterior rhinoscopy, laryngoscopy and endoscopy and also full acquaintance with its various causes. It should be assumed that the symptom is a warning sign of a serious malady until every step has been taken to confirm or disprove this assumption.

To make a definite diagnosis, it is most important to determine the site of bleeding. Usually, the lesion is not bleeding when the patient complaining of blood-spitting is first seen by the examining physician, and the patient frequently has difficulty in localizing the point of bleeding. The physician likewise often encounters difficulty, and his search should encompass (1) the gums, buccal mucosa, tongue, posterior nares, nasopharynx, base of the tongue, and hypopharynx; (2) the upper portion of the gastrointestinal tract; and (3) the larynx and the tracheobronchial tree below.

Seven cases are presented to illustrate the various causes of hemoptysis. Bleeding from the upper portion of the respiratory tract, hematemesis, bleeding from the lower portion of the respiratory tract, hemoptysis associated with tuberculosis, bronchiectasis, carcinoma and heart disease, and idiopathic hemoptysis are discussed, as is also the management of cases of hemoptysis.

The Use of Aerosol Trypsin in Atelectasis Neonatorum. By Edward Balthrop, M.D., and Lawrence Hicks, M.D. South. M. J. 46:914-916 (Sept.) 1953.

Two cases are reported in which persistent atelectasis of the newborn responded to treatment with aerosol trypsin. Studies are presented to demonstrate the viscosity-reducing and protein-digesting action of trypsin on respiratory mucus. It is noted that hyaluronidase and streptokinase-streptodornase do not decrease the viscosity of mucus.

Triethylene Melamine in the Treatment of Lymphomas and Other Neoplastic Diseases. By O. Whitmore Burtner, M.D., Louis C. Jensen, M.D., and John M. Rumball, M.D., F.A.C.P. Ann. Int. Med. 38:1222-1244 (June) 1953.

An evaluation is made of the therapeutic effects of triethylene melamine (TEM), a nitrogen mustard-like compound, given orally in the treatment of Hodgkin's disease, lymphosarcoma, leukemia and miscellaneous neoplasms in a series of 38 cases. The response in all of these cases is summarized in tabular form as is also a clinical comparison of intravenous nitrogen mustard and oral triethylene melamine. In addition, several illustrative cases are reported in detail.

It is concluded that TEM is an important addition to the armamentarium of chemotherapeutic agents used in the palliation of lymphoma and leukemia. Valuable in the treatment of Hodgkin's disease, where its action appears qualitatively similar to that of the nitrogen mustard, HN_2, it is also useful in some cases of lymphosarcoma. Small doses may produce a favorable effect in chronic lymphocytic leukemia. This new compound is indicated when the disease is generalized, in cases in which toxic, constitutional symptoms are present, and in some so-called x-ray-resistant cases. It may also be used advantageously in conjunction with local x-ray therapy.

Easy oral administration, decreased incidence of nausea and vomiting, and adaptability to sustained maintenance therapy give TEM advantages over HN_2. Adequate precautions in its use are advised because of the prolonged cumulative action, the variable dose required for therapeutic response, and the variable tolerance exhibited by individual patients.

Prevention of Postoperative Shock. By John T. Stage, M.D. Am. Surg. 19:432-435 (May) 1953.

In this discussion of the prevention of postoperative shock from the viewpoint of the anesthesiologist, the author develops a pattern of conduct for carrying the average patient through a surgical procedure. Although the problem of postoperative shock actually begins with the preoperative period, in the interest of brevity only the period of induction and the period of surgical manipulation are covered here. The advantages and disadvantages of the various methods and drugs employed, together with related problems, are clearly delineated. Also described is the way in which the anesthesiologist plans ahead for the immediate postoperative period.

In summary, Dr. Stage observes that a review of the mechanisms producing shock maps the course the anesthesiologist must follow. Induction of anesthesia should be physiologic. Maintenance should be carried out at only the necessary depth. Oxygen saturation of the blood stream should be at the highest possible level at all times. The tone and volume of the vascular tree must be maintained. Those agents which can be classified as shock preventers are rare, he notes, being limited to three plasma expanders, dextran, polyvinylpyrrolidone and oxypolygelatin, and a new vasoconstrictor, norepinephrine.

The Psittacosis Problem in Florida. By L. L. Parks, M.D. South. M. J. 46:864-870 (Sept.) 1953.

This paper presents a review of investigations made by representatives of county, state and federal public health services into the problem of psittacosis in Florida early in 1952. It covers an outbreak of psittacosis in birds in which 14 parakeets out of 105 examined were found to be positive. There were no human cases reported in the state. Two cases, however, occurred in Minnesota in patients who had a bird recently purchased in Florida. The bird died and was not examined, but the complement fixation tests of the 2 patients were sufficiently high to make the diagnosis of psittacosis.

It was concluded that the use of permits in the control of this disease is not a practicable control procedure with the present rapid means of transportation. The study indicated that psittacosis is probably endemic among parakeets and also that with the present knowledge of the disease control measures are most difficult. The experience demonstrated a most satisfactory working relationship between the county, state and federal health services.

Treatment of All Fractures of the Upper End of the Femur with the Original One-Piece Flange Nail. By Eugene L. Jewett, M.D., F.A.C.S., F.I.C.S., Fred H. Albee Jr., M.D., A.I.C.S., and F. DeWitt Stanford, M.D. South. M. J. 46:920-924 (Sept.) 1953.

Developments in the treatment of fractures of the upper end of the femur are discussed, and also the entire question of fractures in this location. Methods are described which the authors believe simplify the treatment and handling of patients with such fractures.

They report a series of 345 cases of fracture of the hip, which includes subcapital, transcervical, and paratrochanteric, pertrochanteric and intertrochanteric, which they group together under the new term, pantrochanteric and subtrochanteric types. There was union in 85 per cent of 67 cases of femoral neck fractures, and in 93 per cent of 85 cases of pantrochanteric and subtrochanteric fractures. All of the patients were followed six months or longer, the average for both groups being 26 months. The oldest patient was 97 years of age and the youngest 18; the average age was 73.

The successful use of the Jewett nail in the treatment of subcapital and transcervical neck fractures of the femur depends on certain dicta, which are outlined. A new approach to the treatment of subtrochanteric fractures has been tested and found satisfactory. This approach, which requires the use of a dual flange nail, is described. A new prosthetic device is also described, and its use in 13 hips is discussed.

Ethaverine in the Treatment of Angina Pectoris. By Carl M. Voyles, M.D., Homer A. Sieber, M.D., and Edward S. Orgain, M.D. J. A. M. A. 153:12-14 (Sept. 5) 1953.

In experimental animals it has been shown that ethaverine, the ethyl analogue of papaverine, has a more prolonged and effective vasodilating action on the coronary arteries than papaverine. Accordingly, in order to avoid the common errors of physician enthusiasm and "new drug" psychologic effect on the patient and because angina pectoris exhibits spontaneous variations, a "double-blind" experiment was performed to obtain more accurate evaluation of ethaverine in this disorder. This study, alternating ethaverine with placebo, was made in 22 patients with stabile angina pectoris, whose ages ranged from 40 to 77 years, the average age being 57 years.

The majority of patients reported subjective improvement to an equal degree with both ethaverine and placebo. Ethaverine was no more effective than placebo therapy in reducing the severity or frequency of attacks of angina pectoris. Cyclic variations in frequency and severity of angina pectoris irrespective of medication were noted in this series.

Analysis of Results with the Massachusetts Vision Test, with Recommendations for Improving Its Accuracy. By Curtis D. Benton Jr., M.D. Am. J. Ophth. 36:363-364 (March) 1953.

To obviate dependence on written reports from several different specialists and oral reports from parents in evaluating certain deficiencies in the Massachusetts vision test as applied to school children, a second screening of the children who failed this test twice as given by a school nurse was undertaken in the study here described. The test was given to 2,226 school children by the DeKalb County (Ga.) Health Department staff of nurses. The 410 children who failed on two occasions represented 18.4 per cent of the total. Part I of the test accounted for 37.5 per cent of the total failures, Part II for 52.5 per cent, and Part III for 10 per cent.

Of 304 children who failed the school test and were brought to the clinic for further studies, 163, or 53.6 per cent, were classified as needing no further study, and 141, or 46.4 per cent, were referred for definite eye care. Of those referred, 92.5 per cent needed glasses or some form of treatment. On the basis of his analysis of this series, Dr. Benton recommended the following changes in the Massachusetts vision test:

Part I—Grades 1-3 20/30
Grades 4-7 20/20
Part II—Grades 1-3 +2.25D. sph.
Grades 4-7 +1.75D. sph.
Part III—No change.

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Medical Education Today
A Critical Analysis

The problems of medical schools in this country today are grave. Ignoring them will not solve them, nor will failure to apply to them the resolving force of constructive imagination coupled with that ingenuity which has always characterized a free and literate people. But assuredly, they are being faced and will be solved.

In view of Florida's current interest in efforts to provide medical education for its youth, it seems timely to review the salient features of a critical analysis of the subject entitled "Medical Education Today," by Dean Currier McEwen of New York University College of Medicine.[1] This article was published in the March 15 issue of the New York State Journal of Medicine, which commented editorially that no one will read it without experiencing an elation of the spirit, a sense of high adventure. A summary of the Dean's views follows:

The developments in medical education in recent years have been the natural outcome of the growth of the basic sciences and of technical advances, also of the gradual spread of the full time system of medical faculty appointments. In the wake of this accelerated growth of knowledge came progressive overcrowding of the curriculum and an increasing preoccupation with technical development. So rapid has the advance of scientific knowledge been since World War II that the necessity for revision of technics in teaching is bringing about a movement of major educational significance in the medical schools of the country.

The aim in the present widespread faculty self-analyses is to see how to present the great mass of knowledge to the student through many different departments without having it become departmentalized in his mind, that is, without having him lose the point that it is all part of medicine as a whole and without having him miss the concept of the patient as an individual like himself, beset by all manner of social, economic, and personal stresses in addition to the more particular medical ones. While departmental organization remains, everywhere it is being realized that schedules and teaching programs are the joint responsibility of all departments, and that they must be changed to meet changing conditions.

Perhaps most important of all, it has become

increasingly clear that the student learns best by working things out for himself. The modern application of the clinical clerkship is based on that principle, and its further extension is evidenced in the critical studies being made by basic science departments of their laboratory exercises.

Experimental Programs

Experimental programs aimed at the integration of teaching between departments and the development of the concept of the patient in teaching rather than the disease are in operation in many schools. These experiments vary from minor changes to such fundamental changes in the whole structure of subject presentation as the teaching of a given subject by a team of instructors from several basic science and clinical departments approaching the subject together. In some student laboratories the student is even assigned his own working unit, and departments come to his "laboratory" instead of the student going to theirs.

The great growth of technical knowledge has had its effect on graduate medical education with the residency programs offering a solution. Meanwhile, the development of clinical clerkships for third and fourth year medical students has so encroached on the internship from below and the assistant residency from above that thought is being given to the possibility of combining the fourth year clerkship and the intern year.

The success of the Association of American Medical Colleges in encouraging such curricular studies and experiments has been so great that it has now undertaken a 10 year program of annual teaching institutes on a variety of subjects. Like the experimental programs in the individual schools, this sort of free exchange and cross-fertilization of ideas by inter-school conferences is of immense value and is symptomatic of the ferment in the faculties and of the widespread determination to make needed changes. The recent survey[2] by this organization and the Council of Medical Education and Hospitals of the American Medical Association likewise has fostered these experiments. It also has served to emphasize the excessively heavy teaching responsibilties of the faculties of the medical schools, which cover not alone medical students but also interns, residents, practicing physicians, nurses, research in the field of health and disease, advances in the basic sciences, contributions in the care of the sick, and guidance to federal agencies.

This comprehensive survey resulted in a comparable study[3] of premedical education, which should have a great effect on premedical education and on collegiate education in general. One point emphasized is that the segregation of the student who hopes to study medicine in a circumscribed "premedical course" is a major fault to be corrected. The report should promote better understanding on the part of both premedical advisers and faculties in the colleges, and admissions committees and faculties in the medical schools of the problems and the needs of each other.

Admission to Medical Schools

Among the practical problems, the enormously difficult task of selecting the students who are to study medicine is first of all quantitative. The published figures of the number who apply to a given school give an erroneous impression for each candidate applies to a number of schools. With the multiple applications taken into account, last year 7,703 out of 14,651 were successful in gaining admission to a medical school, the ratio exceeding one to two. Since many of the 14,651 had very mediocre qualifications, some not even meeting minimal standards, "it is apparent that the number of candidates is not too high but, on the contrary, is reaching a seriously low figure." This falling off of applicants has progressed steadily since 1949, for reasons doubtless many and complex. Notable among them are the general decrease in the number of men and women of medical student age resulting from the fall in birth rate of the depression era; increased cost of becoming a physician; growing attractiveness of opportunities in other professional fields, such as engineering and the physical sciences; and the exaggerated impression of the difficulty of gaining admission, an error particularly unfortunate when the number of outstanding candidates is getting critically low throughout the nation as a whole.

A second and much discussed admissions problem is that of discrimination against certain candidates for reasons of race or religion or other similar factors. "It is my honest opinion that discrimination in the sense in which these aggrieved reports use it plays very little role in the selection of medical students in this country. Students of medicine cannot be selected on the basis of academic grades alone. Important as academic

ability is, character, emotional stability, ability to guide and help other people, and intellectual curiosity are no less, or even more, important. I believe that these are the factors which admissions committees take into account and that the reports of discrimination based on racial or other such reasons are usually completely erroneous and, at the worst, are greatly exaggerated. If the time should come when students of medicine are selected solely on the basis of grades, medicine and the public will suffer."

Financial Support

Financial support is a most serious problem. The comparatively small increase in income from student fees, gifts and endowment far from offsets the great increase in operating costs. Publicly supported schools of course have recourse to legislatures, but those privately supported have to fall back on their parent universities, which have come to their aid the best they could but at the expense of curtailing support urgently needed by their other professional and nonprofessional schools. The cost to the medical schools of educating each medical student for one year has risen from about $500 in 1910 to more than $2,000 in 1950. During that same period, however, the annual yield of an investment of $50,000 of endowment has fallen from about $3,000 to $2,000 or less. The general rise in the cost of living accounts in large part for the increase in the cost of educating a medical student. Medical education, however, has contributed to its own rising costs through the scientific advances it has made possible. If this type of progress is to continue in man's struggle against disease and ill health, funds must be forthcoming to keep medical education always advancing. This is a responsibility which the public owes to itself, for the people of the country are the ones who will gain or lose as medical education rises or falls.

Efforts to obtain additional funds might well begin with certain budgetary changes, notably relieving medical school budgets of part at least of the burden they now carry for the care of patients. It has been estimated that the faculty members of the nation's medical schools provided free care to the sick last year valued at at least 100 million dollars — a sum far larger than the annual amount the schools are seeking. In addition, in some instances the hospitals served should absorb certain expenses for technical and clerical personnel, supplies and equipment now carried in the school budgets. A third expense unjustifiably placed on the medical schools is the great expense of research not covered in grants.

To alleviate the financial plight of medical education, the other solution is to obtain greater income. Able students of limited means are so hard pressed now that further increases in tuition would make the system of medical education in the privately supported universities no longer democratically open to all who have the required capabilities. In seeking additional gifts and grants one encounters a curious phenomenon of the times for, whereas funds for worthwhile medical research are currently readily available, it is extremely difficult to obtain support for the basic medical programs which make such research possible. In this situation the efforts of the National Fund for Medical Education and the American Medical Education Foundation are heartening although this enormously helpful support is only a fraction of that needed. Subsidies by local, state or federal governments offer a solution to the problem only if they are so given that neither now nor in the future could they be a threat to the independence of action of the medical schools and their parent universities.

Even a cursory review of Dr. McEwen's critical analysis of this vitally important subject provides convincing evidence that the need is urgent and the state of the nation's health deeply involved. Certainly the highest order of statesmanship in medicine, in government and in other contributing circles should be mobilized for a solution to the dilemma.

1. McEwen, C.: Medical Education Today, New York State J. Med. 54:810-816 (March 15) 1954.
2. Dietrick, J. E., and Berson, R. C.: Medical Schools in the United States at Mid-Century, New York, McGraw-Hill Book Co., Inc., 1953.
3. Severinghaus, A. E.; Carman, H. J., and Cadbury, W. E. Jr.: Preparation for Medical Education in the Liberal Arts College, New York, McGraw-Hill Book Co., Inc., 1953.

EIGHTY-FIRST ANNUAL MEETING

FLORIDA MEDICAL ASSOCIATION

ST. PETERSBURG

APRIL 3-6, 1955

Federal Fireworks Legislation

July always brings the fireworks problem to the fore. This year, the status of federal legislation on this subject is of particular interest for on May 18 the Senate passed by a vote of 73 to 3 the House-approved bill (H.R.116-Church) banning interstate shipment of fireworks to states which prohibit their sale. The preceding day, the Senate adopted the following amendments: (1) exempting fireworks for the use of federal agencies; (2) exempting fireworks used for bird control in farming; and (3) making the measure effective July 1, 1954. The bill then went to conference so that House and Senate differences could be worked out.

Traditionally, since the birth of the country, the use of fireworks has featured the celebration of public and patriotic events, particularly the observance of Independence Day. Increase in injuries from fireworks and other explosives employed in Fourth of July celebrations led to a survey, admittedly incomplete, made by the American Medical Association in 1903, which tabulated 3,983 injuries and 466 deaths. During the next six years, the injuries ranged from 3,986 to 5,460 and the deaths from 158 to 215. Rapid decline to 820 injuries and 30 deaths in 1916 caused the American Medical Association to discontinue its annual survey.[1]

By 1935 there was evidence of considerable increase, and reports were accumulated of 7,738 injuries and 30 deaths that year. A further analysis of 3,000 cases disclosed that more than half of the injured were under 15 years of age, and that two thirds of the casualties were caused by firecrackers. Two years later the American Medical Association once again began analyzing hospital and newspaper reports, an incomplete report for 1937 totaling 7,205 injuries with 20 deaths. During the next few years passage of regulative legislation by a number of states resulted in a decrease to 2,050 injuries and only 11 deaths recorded in 1941 and 896 injuries and 6 deaths in 1946.[1] The 1946 figures represented an 89 per cent change from 7,933 injuries reported in 1938.[2]

Local regulation in hundreds of cities proved inadequate because citizens bootlegged the fireworks to their homes from distributors' stands erected outside the city limits. To promote state legislation, the "Model State Fireworks Law" was prepared in 1937-1938 by the National Fire Protection Association, and today well over half of the national population enjoys its protection. By 1952, 32 states, including Florida (1941), had enacted laws essentially similar in purpose and effect regulating or prohibiting the sale and/or use of fireworks.[1] The value of proper fireworks control legislation is now widely recognized, and such legislation has won widespread approval from medical organizations and many other groups.

The present measure now assured of passage by the Congress grew out of the experience of the state of Illinois. That state in 1950 passed laws prohibiting the sale and/or use of dangerous fireworks, except for use in properly supervised public displays. Nevertheless, there occurred in 1951 a total of 266 accidents, with 201 burns, lacerations and wounds; 9 deaths, 8 of which were in children; and 56 eye injuries with serious impairment of vision in 18 children, 8 of whom were blinded in one eye or lost one eye entirely. Incomplete reports for 1952 indicated at least 216 accidents, with 161 burns, lacerations and wounds, and 55 eye accidents in which 5 children were blinded in one eye or lost one eye.[1]

Investigation of a fire caused by fireworks, which cost the lives of 3 children and injured 5 adults, disclosed that the fireworks were illegally obtained through purchase by mail from a manufacturer in a state where the sale was legal and were shipped into Illinois by an express agency. The addresses of fireworks manufacturers were readily available, to children in particular through advertisements in comic books and children's magazines, frequently with convenient coupons for ordering shipments. It therefore became necessary to make it illegal to transport fireworks for use within the state.

The problems in her state prompted Congresswoman Marguerite Stitt Church to introduce a bill into the House of Representatives of the 82nd Congress (H.R.4528) aimed at stopping the bootlegging of fireworks by putting shippers and carriers on notice that the federal government will not tolerate the use of interstate commerce for the purpose of circumventing state law. Reported favorably too late for action, the bill was reintroduced in the House of the 83rd Congress by Congresswoman Church, and has now made its way successfully through both the House and the Senate. It should put a stop to the mail order bootleg purchases.

The effectiveness of control legislation has been demonstrated by the National Society for the Prevention of Blindness[2] through analysis of the available data on eye injuries contained in the annual reports published by the American Medical Association. For states having the full model law, the average number of eye injuries per year before the law was enacted was 81.5 with loss of one or both eyes in 5 instances, and after enactment of the law 3.1 with no eye loss, representing a change of 96 per cent. The corresponding figures for states with all types of law were 247.5 before with eye loss in 19 and 42.9 after with eye loss in 0.4, or an 83 per cent decrease. In 1938 the eye injuries reported numbered 325 with loss of one or both eyes in 43 cases, and in 1946 they numbered 45 with loss of an eye in 1 case, a difference of 86 per cent. Although these figures are incomplete, the percentages are significant. Certainly constructive legislation and its enforcement regarding the promiscuous use of fireworks can prevent loss of life and much suffering as well as extensive property damage by fire.

1. Reifenstein, E. C. Jr.: Fireworks Casualties: A Preventable Cause of Damage, Disability and Death, J. Oklahoma M. A. 46:122-125 (May) 1953.
2. National Society for the Prevention of Blindness. Personal communication to the Editor.

Impatient Patients Reap New Benefits Under Socialism

There is a new angle to Britain's socialized medicine scheme. Under the British health service, patients now have discovered they can sue the government if they do not get well. Under the legal aid scheme, which is a separate Socialist institution, they can even get the government to furnish them a free lawyer to handle their suit. Furthermore, if they win, the government pays off. If they lose, the court costs still have to be paid by the government.

"So have a go. It's all on the welfare state," writes London correspondent Ernie Hill in the Chicago Daily News. He reports that a rash of lawsuits against hospitals under the National Health Service has broken out all over the place, with medical authorities estimating that some 200 suits for damages have been filed in the last three years. It would seem that there is never a dull moment in the welfare state. We wonder what happens to the doctor who fails to get the patient well.

Joint Study of Indigent Medical Care Problems

A concerted movement of five different groups got under way recently for the purpose of exploring areas in which they might work together to improve medical care for the indigent and the medically indigent population. All five associations have been conducting independent studies over the last few years, and the plan now is to establish a liaison unit through which they can work together. The American Hospital Association, the American Dental Association, the American Public Health Association, the American Public Welfare Association, and the American Medical Association comprise this group.

At their first meeting the representatives named the liaison unit "The Joint Conference Committee to Study Indigent Medical Care Problems." They agreed to prepare a joint statement on the general subject of indigent medical care for submission to and approval of their respective associations. Also, they decided upon one or more field studies during the summer to be conducted by a joint staff representing each of the five associations.

"We hope," said Dr. Henry B. Mulholland, chairman of the Committee on Indigent Care of the A. M. A.'s Council on Medical Service, "to work together in the field of indigent care in the same manner as these associations have worked together in the field of chronic disease. If such a joint conference committee can accomplish as much as the Commission on Chronic Illness, we believe the effort will be well worthwhile." This trend toward united action gives promise for the future.

1954 MEDICAL DISTRICT MEETINGS

"A" Marianna	October 11
"B" Sanford	October 13
"C" Sarasota	October 15
"D" Vero Beach	October 14

Bascom H. Palmer Cited

Again, on April 27, 1954, Bascom H. Palmer received honorable acclaim, heartily approved and happily shared by his friends and confreres. Few doctors of medicine have repeatedly enjoyed such evidence of appreciation.

This occasion was the Eightieth Assembly of the House of Delegates of the Florida Medical Association. Mr. Claud Andrews, Director of Rehabilitation Services of the State of Florida, reviewed a few highlights of Dr. Palmer's work for the blind: tireless efforts through many years and many projects. As stated by Mr. Andrews:

"Dr. Palmer is closely associated with the history of the Miami Lighthouse for the Blind.

"As early as 1932 he was our Medical Chairman and thru his tireless efforts many things so far accomplished can be directly credited to him.

"He donated the property on which the present Lighthouse stands in 1939.

"He served as president of the Board of Directors from 1947 to 1952. His efforts, single-handed, pulled the Lighthouse thru a financial crisis and kept the doors open.

"Thru a one-man campaign and gifts from many of his devoted and grateful patients, he has secured close to the first $100,000 for the Ophthalmic Institute of Miami, which is his dream and hope.

"During his administration as president, as far as we know, the first Negro Lighthouse for the Blind in the United States was established in Miami.

"Thru his guidance, foresight and unfailing good judgment, the Board of Directors purchased the strategic corner property for the Ophthalmic Institute, which will be part of Jackson Memorial Medical Center.

"Without taking any glory from the other faithful and constant members of the Board, it can easily be said that Dr. Palmer is the motivating power behind much of this organization's success."

Mr. Andrews then presented to Dr. Palmer the following Citation conferred by the authority of the President of the United States:



Bascom H. Palmer, M.D.

United States Department of Labor
Washington, D. C.

The President's Committee on National Employ the Physically Handicapped.

This Citation for Outstanding Service is conferred upon Bascom H. Palmer, M.D., in recognition of outstanding efforts expended in promoting equal opportunities in Employment for the Physically Handicapped.

Attested to by the Community Committee on the Employment of the Handicapped in Miami and the Governor's Committee for Florida

(Signed) General Melvin Maas, Chairman
For the President of the United States
Dwight D. Eisenhower

"Bascom" has acquired and retained personal friendships throughout Florida since he was born in Lake City in 1889. The folks in the Suwannee River Valley still claim him as one of them-

selves, even as Dade Countians consider him their own. In Columbia County, Dr. R. B. Harkness (born in '72) chuckles as he recalls Bascom's return with his M.D. degree to his home town. Dr. Tom Bates and many others there are proud because of Bascom's stature.

Here in Dade County, a multitude acknowledge the initiative, the pioneering leadership, the evangelistic persuasion, the unyielding tenacity of convictions and the professional acumen and superlative technic that characterize Dr. Bascom H. Palmer. His exhausting labors have supported the progress of his profession, its institutions and organizations, civic and educational programs.

In recognition of his work, accredited by those persons most closely associated with him as well as by the beneficiaries of his services, many honors have been extended. Dr. Palmer is an Honorary Member of the Rotary Club of Miami and is an Honorary Member of the Board of Trustees of the University of Miami.

Dr. Palmer's expenditure of himself has been a public contribution supplemented and supported by those closest to his heart, his wife Helen, his daughters, Nancy and Sally, and his grandchildren.

He has earned a stature, rare among men: Those who may not consider him friend do respect him.

Robert T. Spicer, M.D.

Southern Pediatric Seminar July 12-31, 1954

For the thirty-fourth year, the Southern Pediatric Seminar will hold its annual session during July at Saluda, N. C. The course is a postgraduate seminar in Internal Medicine, Obstetrics and Gynecology, and Pediatrics with presentation of the newest methods of diagnosis, prevention and treatment. In all these fields, the lecturers stress the solution of ordinary daily problems in the most modern, scientific and satisfactory way. The course is designed to fit the needs of the general practitioner, and credit for attendance is accepted, hour for hour, by the American Academy of General Practice.

The first week, July 12 through July 17, is devoted to Pediatrics and Internal Medicine; the second week, July 19 through July 24, to Pediatrics; and the third week, July 26 through July 31, to Obstetrics and Gynecology.

The lecturers are among the foremost medical authorities in the South. The faculty, a happily balanced combination of professors and practitioners, volunteer their services to create a unique teaching center where the most advanced information is presented in an informal atmosphere. In addition, special guest lecturers join the teaching staff to add freshness and divergent points of view. Florida physicians on the faculty are Dr. Hugh A. Carithers, of Jacksonville, and Dr. Warren W. Quillian, of Coral Gables, a past president of the American Academy of Pediatrics.

Advance registration is requested because classes are limited to 125. For information and registration address M. A. Owings, Secretary-Treasurer, Saluda, N. C.

Graduate Medical Education Short Course, July 12-16

The program for the Twenty-Second Annual Graduate Short Course, to be held at the George Washington Hotel in Jacksonville July 12-16, was published in detail in the June issue of The Journal. Attention is directed to the meeting on Monday, July 12, at 8 p.m. Dr. Hans Lowenbach, Professor of Psychiatry, Duke University School of Medicine, will speak at this meeting, to which the public will be invited. His subject is "Conflict and Confidence." Several organizations, including the Northeast Florida Association for Mental Health, are sponsoring this meeting.

The August issue of The Journal will give the exact date in November when the course in Hematology, to be presented by Dr. William Dameshek, will be given. The availability of a large number of microscopes and of sufficient clinical material makes it necessary to hold this course in Jacksonville.

The details of the meeting of the Florida Clinical Diabetes Association, to be held October 21 and 22, will also appear in the next issue of The Journal. In addition to the regular meeting of the association, on two days there will be lectures on diseases of metabolism. These lectures will be given by Dr. H. B. Mulholland of the University of Virginia School of Medicine, and Dr. Joseph T. Beardwoo Jr., of Philadelphia.

OTHERS ARE SAYING

No Recession for Medicine

The bumper baby crop of 4 million in 1953, the highest ever, continuing the high plateau which has been present for fourteen years and which seems to show no inclination for its slacking off, together with the ever increasing span in life, will certainly increase the demand for physicians for years to come. The elementary schools, high schools, and universities are jammed to overflowing now and pose problems of critical teacher shortages.

From the physicians' viewpoint, the health needs of this expanding population will continue to mount. Medicine and all ancillary professions will find shortages in personnel as the need increases. Technological advances in industry have cut down the number of workers needed as far as production is concerned. However, workers needed in the so-called services, including the professions, will increase.

With families increasing in size and incomes being high, there has been a tremendous exodus from the center of cities to the suburbs while the cities have remained stagnant. Therefore, doctors' offices and practices will more and more be located in the rapidly growing suburbs.

If you are planning to move to another state, the best states for both growth and income are Colorado, Nevada, Oregon, Washington, Maryland, Michigan, Delaware, Connecticut, and Ohio. Some of those with poor growth and low income are Mississippi, Arkansas, and Alabama. Wisconsin's average income is medium and its rate of growth is 16 per cent, with 18 per cent being about the average. The United States population is now 161 million; expected in 1960, 168 million; 1990, 250 million. Wonder where they will hold the A.M.A. convention in 1990.

—*The Wisconsin Medical Journal, March 1954*

"Today's Health"

Today's Health is a high-class magazine published by the American Medical Association under the very able editorship of Doctor W. W. Bauer. This magazine is a source of reliable information for the public, couched in language the average reader can understand. It is filled with items the public is entitled to know, and does not dwell upon untried medicines, operations, or theories. It contains the answers to many questions your patients would like to ask you, and does so in an authoritative manner. *Today's Health* is an "exceedingly important and efficacious medium in the public relations and public education in health functions of the American Medical Association."

Today's Health has a total subscription of 260,000, but of this number only 26,000 subscribers are doctors. This important magazine has an annual deficit of $150,000. This deficit could be wiped out if 100,000 doctors were subscribers, instead of the 26,000. It certainly is better to have your patients read their medicine from *Today's Health,* while they sit in your reception room, than to get it from the Saturday Evening Post, Collier's, the Red Book, or from the Ladies' Home Journal, and its cost is very much less than the price of any of those named.

Why not send in your subscription, Doctor, while you think of it?

—*The Nebraska State Medical Journal, February 1954*

What Is The Fee For?

Not so long ago, one of our members was recounting a not too unusual experience. While making an evening call to care for a sick child, his visit was interrupted by the arrival of a TV repairman to service the television set at the home of this family. Following a check of the set and replacement of a tube, the family paid a ten dollar service charge happily and the repairman left. Later, after a time-consuming history-taking, a thorough examination of the child, making a diagnosis and instituting therapy, the doctor prepared to leave, long after the repairman had come and gone. When he was asked his fee — which was a little over half of the repairman's charge — the family let it be known they felt it too much and told him he would have to wait for his money.

This experience is not new to doctors, but we have learned to accept it gracefully since we real-

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ize the psychologic reasons behind it. People resent being sick and having to pay for medical care to get well! Few include provisions in their budget for this, and then are frustrated when money ear-marked for another cause, has to be paid to regain their health — something they feel should be theirs without any cost to them.

When we examine current national surveys on the cost of illness, we find that hospital, drugs, and appliance costs have skyrocketed, yet the doctor's charges have increased very little in comparison. Medicine can be very proud of its individual physician's effort to hold the line in this time of spiraling inflation. However, when an incident as recounted above occurs to us, we feel on the one hand that we are not being realistic in our charges by comparison, and on the other hand we are made to feel by the patient that we are out of line with other doctors' charges.

—Reprinted from the Lucas County (Ohio) Medical Society Bulletin in The Pennsylvania Medical Journal, March 1954

Social Security

Doctors, like all other citizens, should be aware of the following facts:

—Over $7 billion was spent by the Federal Government for Social Security, health, and welfare, in 1953.

—A recipient of the meager old age benefits must sacrifice his benefits if he earns more than $75 per month in his effort to supplement them.

—An alien working in the United States may become eligible to receive $85 per month by paying as little as $81. He may then return to his home land, marry, raise a family, and receive these benefits for himself and a family for life. He may do this with no restriction on his earnings.

—Between 1940 and 1953, the number of recipients of OASI benefits living abroad increased from 100 to 30,145.

—Over six million persons paid Social Security taxes and died without receiving any benefits.

—Over half a million aged persons receive the minimum, $25 monthly, and only 53,000 receive $85.

Do you want Social Security?

—The Nebraska State Medical Journal. April 1954

Cost of Medical Education

Medical college training in America costs approximately $9,200 today, according to a survey made recently for the *Journal of Medical Education*. The figures were based on questionnaires sent to students at 26 medical schools throughout the country.

The $9,200 does not cover the cost of premedical training, internship, and residency training, or the cost to the young physician of setting himself up in practice.

One-third of the 6,251 students who answered expect to be in debt when they graduate from medical school, and the amount of debt averages approximately $3,500. About half of the students are single and live away from home. Most of the money for education for the single student comes from his parents, while the married student is supported largely by the earnings of his wife. Income of all students varies widely, with an average of $2,450.

—The Journal of the Kansas Medical Society, March 1954

Welcome to a New Magazine

It is always a happy occasion to welcome a new magazine to the field of medical publications. Thus it is a pleasure to read Vol. 1, No. 1 of the new WORLD MEDICAL JOURNAL.

Congratulations go to the new editor, Austin Smith, M.D., to the publications committee of the World Medical Association and to the printers, Stuyvesant Press of New York, for an outstanding example of modern medical journalism.

Printed in three languages — English, French and Spanish — the new Journal replaces the former Bulletin of the WMA which was discontinued in October 1953.

The World Medical Association is a unique organization consisting of national medical societies of the various countries. This is in contrast to WHO — the World Health Organization — which represents the respective governments.

Individual membership in the World Medical Association is open to physicians who are members of their respective national medical societies. The United States Committee of WMA will welcome inquiries on membership at its office — 345 East 46th Street, New York 17, N. Y.

—New York Medicine, March 5, 1954

STATE BOARD OF HEATLH

Services at Tumor Clinics

A frequent complaint made by the tumor clinic directors and physicians who give their time to the tumor clinics should be of interest to all physicians. These complaints pertain to the referral of patients by the attending physicians for general diagnosis and failure to work up the cases prior to referral to the tumor clinic.

There are 18 approved tumor clinics operating in the state. These clinics are supported in part by the American Cancer Society, the State Board of Health, or both, and the hospital where the clinic operates.

The purpose of the clinics is to offer diagnostic services in suspected cases of cancer, primarily for indigent persons. No patient is expected to come to the clinic for services without first having a referral from a physician. Occasionally private patients are seen if the attending physician desires the advice of the tumor clinic staff and accompanies his patient to the clinic. Policies differ in each clinic, but the clinics are primarily for medically indigent patients.

The hours for the clinics are short because of the limited time the staff physicians can give from their practice to this service. The physicians who take part in the tumor clinics are not receiving remuneration from any source for their services. These clinics are not general diagnostic clinics, but are restricted to cases of cancer of suspected cancer. Patients are being referred to some of the clinics who have no suspicion of cancer, and this type of patient tends to overload the clinic.

Each patient referred to the tumor clinic should have the proper authorizaton for state aid or a completed application for it, a brief clinical history and reports of any laboratory work, including biopsy reports already made on the patient. For example, if the attending physician refers a patient with a cancer of the cervix, or this lesion is suspected, a biopsy should be performed before the patient reports to the tumor clinic, and the report on this biopsy should be taken or sent to the clinic with the patient. Obtaining the specimen for biopsy by the attending physician when the patient is first seen helps to make an earlier diagnosis and saves the time of the tumor clinic staff.

More than two years ago the pathologists of the state agreed to perform the tissue examination free of charge if the attending physician made no charge for taking a specimen for biopsy. This policy is still in effect. The suspected tissue removed may be placed in a small laboratory container with a little 10 per cent formaldehyde solution and sent to the pathologist of the physician's choice with a statement that the patient is medically indigent. This service by the pathologists of the state makes it possible for any physician to get an early diagnosis in the indigent case.

Needless to say, all patients should have a complete physical examination before being referred to the clinic, and in this way the tumor clinic will not be overburdened with noncancerous or nonsuspected cancer cases. The tumor clinic staff is most anxious to see all patients in whom cancer is suspected, and the cooperation of the referring physician in restricting the referrals to the cancer field will be appreciated.

The payment by the State Board of Health for hospitalization of patients with cancer is still restricted to the indigent cases that have been processed through one of the approved tumor clinics, provided proper authorization has been obtained in each case.

BIRTHS AND DEATHS

Births

Dr. and Mrs. Floyd L. Pichler of Jacksonville announce the birth of a daughter, Bonnie Kay, on March 31, 1954.

Dr. Doris N. Carson (Mrs. Dale Carson) and Mr. Dale Carson of Jacksonville announce the birth of a son, Chris LeRoy, on April 13, 1954.

Dr. and Mrs. Jesse H. Belyeu of Jacksonville announce the birth of a daughter, Lynn Renee, on May 25, 1954.

Dr. and Mrs. Morris A. Price of Jacksonville announce the birth of a daughter, Barbara Ilene, on June 1, 1954.

Dr. and Mrs. David B. Manley of Lake Butler announce the birth of daughter, Bernadette Claire, on June 6, 1954.

Dr. and Mrs. Joseph J. Lowenthal of Jacksonville announce the birth of a son, Joseph J. Jr., on June 8, 1954.

Deaths — Members

Stetson, Alexander G. C., Lakeland	Dec. 29, 1953
Stuart, J. Dever, Miami	May 27, 1954

Deaths — Other Doctors

Romberger, Floyd T. Jr., Indianapolis	Jan. 1, 1954
Pittman, James L. Jr., Atlanta, Ga.	Jan. 21, 1954
Bergman, Sam, New Orleans	April 16, 1954
Caudle, Richard S., Tampa	April 24, 1954
Galison, Louis, Coral Gables	April 27, 1954
Hubbard, Roger E., Riviera Beach	May 12, 1954
Kebe, George B. (Col.) Gainesville	May 26, 1954

WANTED — FOR SALE

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

GENERAL SURGEON: 38; Board certified; training just completed; category IV; family; Florida license; University training; desires association or partnership leading to a permanent position. Write 69-112, P.O. Box 1018, Jacksonville, Fla.

WANTED: Experienced Laboratory Technologist. Must be qualified in all laboratory work except tissue. Watson Clinic, Lakeland, Florida.

INTERNIST: 34, American Board, Florida Licensure, University Hospital training five years, veteran, married, desires association with internist or group. Write 69-125, P.O. Box 1018, Jacksonville, Fla.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Batsche, Joseph H., Fort Pierce
Bianchi, Dominick A., Jacksonville
Brendle, Luther A., Ocala
Burley, Lee, Sebring
Campbell, Meredith F., Miami
Culpepper, Stuart P., Ocoee
Darty, Warren G., Palmetto
Davis, Earl S., Naples
Fleming, Jack W., Pensacola
Gillespie, Elmer H., Clearwater
Gouldman, Edwin F., Miami
Griggs, Thos. S., Miami
Hartman, Clifford D., St. Petersburg
Johnson, Maurice N., Pensacola
Kelso, Kip G., Vero Beach
Kraemer, Eugene A. Jr., Tampa
Meeko, Robert F., Fort Pierce
Mendelblatt, David L., St. Petersburg
Michaelson, Allen K., Miami
Murr, Claude V. Jr., St. Petersburg
O'Brien, Paul S., Stuart
Rask, Arthur T., Lake Worth
Weber, Henry C., Daytona Beach
Wells, Leila H., Jacksonville
Yost, Orin R., Ormond Beach
Zimmerman, Daniel H., Miami Beach

STATE NEWS ITEMS

Plans are now underway for the preparation of the Scientific Program for the Eighty-first Annual Meeting of the Florida Medical Association to be held in St. Petersburg, beginning April 3, 1955.

It is most desirable that the high quality of the previous programs be continued. In order to do this, your committee must have many papers on a wide range of subjects. It is, therefore, urged that you submit any proposed papers together with a brief resume of the subject to be discussed to the committee at an early date.

Applications must be received by early November, 1954, and should be mailed to Chas. J. Collins, M.D., Chairman, Scientific Work Committee, 1503 Kuhl Ave., Orlando.

Specialty groups desiring their speakers on the state program must advise the Scientific Work Committee by November also.

The annual meeting of the Florida Association of Blood Banks was held at Ponte Vedra Beach May 15-16. Among those taking part in the program were Dr. John B. Ross who participated in a round table discussion on the Clearing House of the Florida Association of Blood Banks, and Dr. Leila H. Wells who gave a demonstration on "Bone Marrow Sections from Clotted Blood." Both of these doctors are from Jacksonville. Miami doctors on the program included Drs. Donald W. Smith, Edward W. Cullipher and Francis N. Cooke who presented a paper on "Blood Vessel and Bone Banking," and Dr. James J. Griffitts who took part in a Clinical Pathological Conference. Dr. William W. Schildecker of Daytona Beach spoke on "A Red Cross Community Blood Bank," and addresses of welcome were delivered by Drs. James J. DeVito of St. Augustine, president of the St. Johns County Medical Society, and Karl B. Hanson of Jacksonville, president of the Duval County Medical Society.

At the meeting Dr. John T. Stage of Jacksonville was installed as president. Dr. Louis E. Pohlman of Orlando was elected president-elect, and Dr. John B. Ross, secretary.

Dr. Sidney Davidson of Lake Worth has been appointed to the Board of Governors of the American Diabetes Association to serve as Governor for the state of Florida.

Dr. Robert E. Rothermel of St. Petersburg spoke on the regulations for foster boarding homes and day nurseries at a meeting of the association of operators of the homes in May.

Dr. Theodore W. Weeks Jr. of Tallahassee has been named director of the joint health departments of Highlands, Hendry and Glades Counties.

Dr. John M. Gunsolus of Stuart spoke at a meeting of the Fort Pierce Rotary Club in May. His subject was the need for more aid for the mentally ill of Florida.

Dr. Nathan L. Marcus of Tampa led an open forum at a meeting of the Licensed Practical Nurses Association on May 14.

Dr. Charles McD. Harris Jr. of West Palm Beach spoke at a meeting of the Rotary Club of that city on May 11. His subject was lung cancer.

Dr. James T. Shelden of Lakeland spoke at a meeting of the Florida State Nurses Association, District 12, on April 5. His subject was cancer.

Dr. C. W. Shackelford of Panama City spoke on cancer at a meeting of the Florida State Nurses Association, District 22, on April 5.

The Fourth Annual Seminar of the Miami Pediatric Society was held April 7-10. Among the speical guests at the Seminar were Dr. Hillard W. Willis, Coral Gables, president of the Pediatric Society; and Drs. George Lister and Robert F. Mikell of Miami. Dr. Philip J. Chastain of Coral Gables was in charge of arrangements.

Dr. Ralph W. Jack of Miami has been appointed to the Board of Directors of the Cancer Institute of Miami.

Dr. C. Ashley Bird of Jacksonville attended the meeting of the American Urological Association in Washington, D. C., in April.

Dr. Shaler Richardson of Jacksonville attended the meeting of the American Ophthalmological Society held at the Many Glacier Hotel in Glacier Park, Mont., June 16-18.

Dr. John H. Kay of Panama City has been named medical director for the Bay County Chapter of the American Cancer Society.

Dr. William H. Turnley of Ocala was initiated to alumnus membership in Phi Beta Kappa at the annual dinner of the honorary fraternity held at the University of Florida in Gainesville recently. The honor was given in recognition of scholarly achievements in the field of medicine since graduation from that institution.

Dr. Gunnard J. Antell of Coral Gables discussed a film on "Children's Emotions" at the Mental Health Fair held in Miami in May.

Drs. Alexander H. Bluestone, Maxwell M. Hartman, Bernard Milloff, Bernard B. Seltzer and Norman N. Wrubel of Hollywood were among doctors taking part in a symposium on "Modern Advances in Medicine" at a regular meeting of the Temple Sinai membership in May.

Dr. Don C. Robertson of Orlando spoke on cancer at a meeting of the Orlando Shrine Club on May 4.

Drs. William L. Fitts 3rd, John P. Gifford, Kip G. Kelso, and James C. Robertson of Vero Beach were among doctors taking part in a symposium on children's diseases, fluorination of water and the value of a well rounded diet at the regular May meeting of the Indian River County P.-T.A. The symposium was arranged by Dr. Fitts.

Dr. Emil M. Isberg of Miami Beach spoke at an opening session of the Mental Health Fair held at White Temple Methodist Church in Miami in May.

Dr. Leo M. Wachtel of Jacksonville was guest speaker at the monthly dinner meeting of the Pharmaceutical Representatives Association at the Seminole Hotel in that city in May.

Dr. Ralph Herz of Key West spoke on "Subfascial Fat Herniation as a Cause of Low Back Pain" at the Surgical Pathological Conference held at Kings County Hospital, Brooklyn, on May 17.

Dr. Samuel M. Day of Jacksonville spoke on "Surgical Treatment of Peptic Ulcers" before the graduate nurses in the service training program at St. Vincent's Hospital on June 8.

Dr. Day spoke at the regular meeting of the St. Johns County Medical Society in May. His subject was "Treatment of Gastrointestinal Cancer."

Dr. Gretchen V. Squires of Pensacola spoke at two theatres after the showing of the film, "Cancer of the Breast." A question and answer period was conducted.

Dr. Hollis F. Garrard of Miami took part in a panel discussion on health at a meeting of the Horace Mann School P.-T.A. on April 22.

Dr. Wiley T. Simpson of Winter Haven has returned to his practice after attending the New Orleans Graduate Medical Assembly.

Dr. Leffie M. Carlton Jr. of Tampa has been appointed chairman of the medical affairs committee of the Greater Tampa Chamber of Commerce.

Dr. Clarence M. Sharp of Jacksonville spoke on "Our Unfinished Business" at the annual meeting of the Polk County Tuberculosis and Health Association held at Florida Southern College in Lakeland on April 22. Dr. Sharp spoke on "Tuberculosis Control" at the annual meeting of the Tuberculosis Association of Duval County.

Dr. W. W. Bauer, director of health education, radio and television for the American Medical Association and editor of the A.M.A. health magazine, "Today's Health," spoke before a meeting of the Woodlawn P.-T.A. of St. Petersburg on April 20. His subject was "Stop Annoying Your Children."

Drs. Joseph L. Selden Jr. and John S. Stewart of Fort Myers spoke on cancer at a meeting held in the school auditorium in La Belle on April 7.

Dr. Duncan T. McEwan of Orlando spoke briefly on the subject of breast cancer after the showing of the film, "Breast Self-examination," at a local theatre in May.

Dr. Hawley H. Seiler of Tampa presented a paper on Thoracic Surgery at a meeting of the American Association for Thoracic Surgeons in Montreal recently.

Dr. Ashbel C. Williams of Jacksonville spoke on cancer at the April meeting of the Auxiliary of the Northeast Florida Optometric Association.

Dr. Sullivan G. Bedell of Jacksonville took part in a panel discussion on "Accomplishments of the Past and Goals of the Future," at the April meeting of the Northeastern Florida Association for Mental Health.

Dr. DeWitt C. Daughtry of Miami presented a paper on "Mediastinal and Para-mediastinal Tumors" at the recent meeting of the Alabama State Medical Association in Mobile, Ala. Dr. Daughtry attended the meeting of the American Association for Thoracic Surgery in Montreal in May and was elected to membership in the association.

Dr. Donald W. Smith of Miami spoke at a meeting of the Miami Acacia Club on April 9. His subject was cancer. A film on lung cancer, "Warning Shadow," was shown.

Dr. George W. Karelas of Newberry was guest speaker at a meeting of the Trenton Lions Club on April 5.

Dr. John T. Stage of Jacksonville discussed a paper on "Sickle Cell Anemia" at a meeting of the Southeastern Anesthesiologist Association in Miami in April.

Dr. O. E. Harrell of Jacksonville has been elected a vice president of the Duval County Federation of Dads' Clubs. He is president of the Landon High School Dads' Club.

Dr. Bruce M. Hogg of Miami spoke on cancer at a meeting of the Veterans of Foreign Wars in the VFW Hall on April 21.

Dr. William Gernon of Lake Worth was presented an honor plaque by the Lions Club of that city at a luncheon meeting in April. The award was made in appreciation of his services with the Lions Sight Conservation Committee from 1952 to 1954. Dr. Gernon spoke at the meeting on sight conservation.

Drs. John J. Fisher, Paul F. Hutchins and Cornelia M. Carithers of Jacksonville have been named to the Board of Directors of the Duval County Chapter of the National Polio Foundation.

Dr. Herbert E. White of St. Augustine has been presented a Nathan W. Collier award for meritorious and outstanding service in work among the Negro people. The awards were presented by the Board of Trustees of the Florida Normal and Industrial Memorial College in St. Augustine at the Sixty-second Annual Commencement Exercises on May 24.

Dr. Raymond H. King of Jacksonville has been re-elected vice president of the Jacksonville Historical Society. Dr. Webster Merritt is a member of the advisory board of the society.

Dr. George I. Raybin of Jacksonville spoke on "Orthopedic Problems of Children" at the regular monthly meeting of the Duval County Academy of General Practice on June 29 in the Sellers Auditorium in Jacksonville.

Dr. William S. Johnson of Lakeland addressed a meeting of the Polk County Association for Retarded Children on April 29. His subject was "What Constitutes a Retarded Child."

Dr. C. Burling Roesch of Jacksonville spoke at the monthly dinner meeting of the Men of the St. Johns Presbyterian Church on April 27. Dr. Roesch's subject was cancer, and the film, "Warning Shadow," was shown.

Dr. Gretchen V. Squires and George W. Morse of Pensacola spoke at the meeting to open the Cancer Crusade in the Fort Walton Beach area. Dr. Squires spoke on "Early Detection and Laboratory Diagnosis of Cancer," and Dr. Morse spoke on "What Surgery Has To Offer in Cure of Cancer."

Dr. Alvin E. Murphy of Palm Beach was honored on May 5 by the Board of Directors of the Heart Association of Palm Beach County. The surprise affair celebrated his recent installation as president of the Florida Heart Association.

Election of delegates to the meeting of the Woman's Auxiliary to the American Medical Association, June 21-25, was held at the meeting of the Woman's Auxiliary to the Florida Medical Association in Hollywood. The delegation to San Francisco was headed by the president, Mrs. Richard F. Stover, and included: Mrs. Burton F. Barney, West Palm Beach; Mrs. Milton M. Coplan, Miami; Mrs. Burns A. Dobbins Jr., Fort Lauderdale; Mrs. Edward F. Fox, Miami; Mrs. V. Marklin Johnson, West Palm Beach; Mrs. Thomas C. Kenaston, Cocoa; Mrs. Sidney G. Kennedy Jr., Pensacola; Mrs. James K. McCorkle, St. Petersburg; Mrs. James N. Patterson, Tampa; Mrs. Frederick P. Poppe, Coral Gables; Mrs. George T. F. Rahilly, Fort Lauderdale; Mrs. John R. Ramey, Miami; Mrs. James W. Sapp, Havana; and Mrs. Randolph Shevach, Miami Beach. Mrs. John M. Butcher, Sarasota; Mrs. Duncan T. McEwan, Orlando, and Mrs. Wade S. Rizk, Jacksonville, were elected as alternates.

Mrs. Richard F. Stover attended the meeting of the Board of Directors of the National Association for Mental Health in New York, June 4-6. She is a member of that Board of Directors. As well as being Today's Health Chairman for the Woman's Auxiliary to the American Medical Association, she will also serve on the nominating committee for that organization this year.

Mrs. James L. Anderson of Miami and Mrs. Samuel S. Lombardo of Jacksonville are serving again this year as members on the Board of the Florida Chapter, American Cancer Society.

Mrs. George D. Feldner, president of the Woman's Auxiliary to the Southern Medical Association, who was a guest of the State Auxiliary at the convention in Hollywood, invited all to attend the annual meeting of that organization which is to be held in St. Louis, Nov. 8-11, 1954. Mrs. Feldner who is from New Orleans was a most gracious and inspiring guest.

COMPONENT SOCIETY NOTES

Brevard

The regular monthly meeting of the Brevard County Medical Society was held on May 11 at the Bahama Beach Club. Dr. Norman B. Edgerton, county health officer, spoke on gamma globulin.

Broward

At the regular monthly meeting of the Broward County Medical Association on May 25, Dr. John H. Mickley spoke on "Treatment of the Common Poisons."

Hillsborough

At the regular meeting of the Hillsborough County Medical Association on June 1, the guest speaker was Dr. C. R. Stephen, Professor of Anesthesiology at the Duke University School of Medicine. Dr. Stephen spoke on "Analgesia and Anesthesia With Tri Chlorethelin (Trilene)." Dr. James M. McEwen spoke on the physicians' responsibility in filing death certificates.

Marion

The regular meeting of the Marion County Medical Society was held on May 18 in Ocala. Guest speaker was Dr. C. Burling Roesch of Jacksonville who spoke on "Differential Diagnosis of Thoracic Lesions."

Nassau

The Nassau County Medical Society has paid 100 per cent of its state dues for 1954.

Pinellas

At the regular monthly meeting of the Pinellas County Medical Society on June 7, Dr. John P. Rowell presented a paper on "Effect of Cortisone on Infections."

St. Johns

At the regular May meeting of the St. Johns County Medical Society, guest speaker was Dr. Samuel M. Day of Jacksonville, Secretary of the Association, who gave a talk on "Treatment of Gastrointestinal Cancer." Accompanying Dr. Day was Mr. Ernest R. Gibson, Managing Director.

Suwannee

The Suwannee County Medical Society has paid 100 per cent of its state dues for 1954.

OBITUARIES

Dwight Irven Roush

Dr. Dwight Irven Roush of Pinellas Park died at his home on March 4, 1954. He was 79 years of age.

Born in Elida, Ohio, on Jan. 15, 1875, Dr. Roush was a graduate of Ohio Wesleyan College. In 1915, he received the degree of Doctor of Medicine from Hahnemann Medical College and Hospital in Chicago.

For many years Dr. Roush was surgeon for the Nickle Plate Railroad. Seven years ago he came to Florida from Brimfield, Ind., and engaged in the general practice of medicine in Pinellas Park. He became the town's first physician in 20 years and held that position for several years. Locally, he was a member of the Wesleyan Methodist Church. Last September he was named as head of a group of businessmen seeking a charter for a bank in Pinellas Park.

Dr. Roush was a member of the Pinellas County Medical Society, the Florida Medical Association, the American Medical Association, and the American Association of Railway Surgeons.

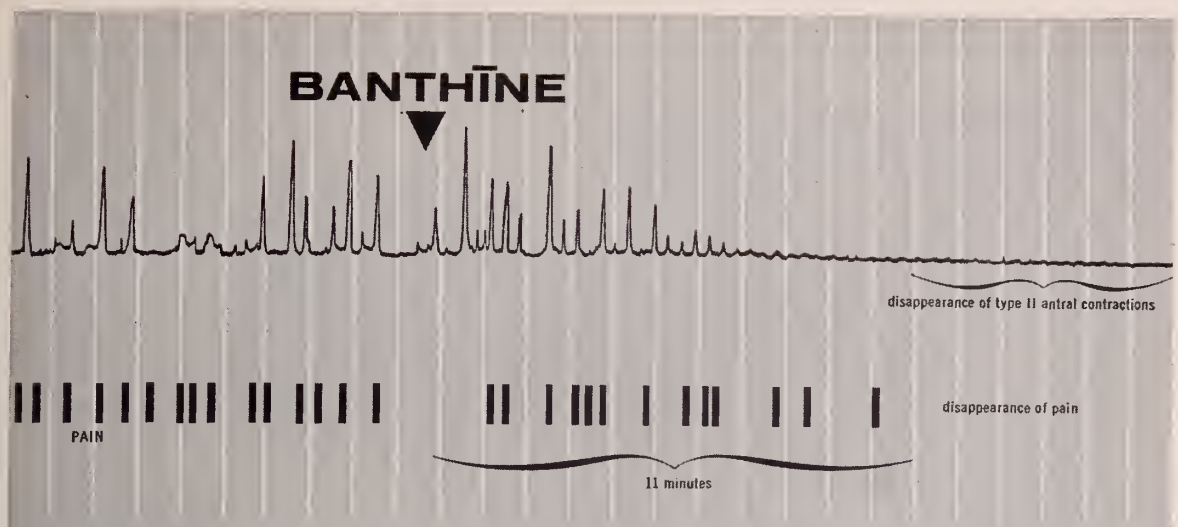
Surviving are the widow, Mrs. Flora Foster Roush, of Pinellas Park; a daughter, Miss Ruth E. Roush, of Springfield, Ohio; and a son, Dwight Cabot Roush, of Pinellas Park.

John Kirk Norwood

Dr. John Kirk Norwood of Jacksonville died suddenly at his home on Feb. 19, 1954. He was 61 years of age.

A native Floridian, Dr. Norwood was born in Micanopy on Aug. 12, 1892. He attended the old Duval High School in Jacksonville. In 1916 he was graduated from the Vanderbilt University School of Medicine, and following an internship at Bellevue Hospital in New York City, he served

(Continued on page 65)



Effect of 100 mg. of Banthīne administered orally on antral gastric motility and duodenal ulcer pain.[2]

Hightower, N. C., Jr., and Gambill, E. E.: Gastroenterology 23:244 (Feb.) 1953

Banthīne® Reduces Hypermotility and Hyperacidity in Peptic Ulcer

A recent evaluation of anticholinergic therapy in peptic ulcer emphasizes the fact that now the profession has at its disposal agents that are "effective in reducing both secretory and motor activity of the stomach."

The effect on motor activity is generally more pronounced and less variable than on secretion; pain relief is usually prompt; a high degree of effectiveness is noted in ambulatory ulcer patients.

Ruffin, J. M.; Texter, E. C., Jr.; Carter, D. D., and Baylin, G. J.: J.A.M.A. 153:1159 (Nov. 28) 1953.

With its proved anticholinergic effectiveness, Banthine has been found extremely useful in the medical management of active peptic ulcer, whether duodenal, gastric or marginal.

The immediate increase in subjective well-being and the simplicity of the Banthine regimen assures patient cooperation. The recommended initial therapeutic dose is 50 or 100 mg. (one or two tablets) every six hours around the clock, with subsequent individual adjustment. The usual measures of diet regulation, rest and relaxation should be followed.

Banthine is effective in other conditions caused by excess parasympathetic stimulation. These include hypertrophic gastritis, acute and chronic pancreatitis, biliary dyskinesia and hyperhidrosis. Banthine is contraindicated in the presence of glaucoma and should be used with caution in the presence of severe cardiac disease or prostatic hypertrophy.

Banthine® bromide (brand of methantheline bromide) is supplied in scored tablets of 50 mg. and in ampuls of 50 mg. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.



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SELSUN is remarkably simple to use. Your patients apply it and rinse it out while washing the hair. It takes little time. No complicated procedures or messy ointments. Ethically advertised and dispensed only on prescription. In 4-fluidounce bottles with complete directions on the label.

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1. Slepyan, A. H. (1952), Arch. Dermat. & Syph., 65:228, February. 2. Slinger, W. N. and Hubbard, D. M. (1951), *ibid.*, 64:41, July. 3. Sauer, G. C. (1952), J. Missouri M. A., 49:911, November.

1-348-54

(Continued from page 62)

as a captain in the Army Medical Corps during World War I.

Upon discharge from military service in August 1919, Dr. Norwood entered the private practice of medicine in Jacksonville. For nearly 27 years, he served as city physician. He was a member of the staff of the Duval Medical Center, St. Luke's Hospital, and St. Vincent's Hospital. For a number of years he was president of the Jacksonville Baseball Club of the South Atlantic League, and his interest in football was great. His fraternity was Sigma Chi.

Dr. Norwood was a member of the Duval County Medical Society and had been a member of the Florida Medical Association since 1925. He also held membership in the American Medical Association.

Survivors are the widow, Mrs. Jessica B. Norwood; his mother, Mrs. Charlotte Norwood; and two daughters, Miss Jean and Miss Jessica Norwood, all of Jacksonville; and a sister, Mrs. Belle Reagan, of Weaverville, N. C.

John Edwin Granade

Dr. John Edwin Granade, colonel, United States Army Medical Corps, retired, of Bradenton, died on Feb. 20, 1954, at the Tampa Municipal Hospital in Tampa. He was 46 years of age. Interment took place in Arlington National Cemetery.

A native of Georgia, Dr. Granade was born in Stone Mountain on June 28, 1907. In 1927, he was awarded the Bachelor of Science degree by Mercer University. The degree of Doctor of Medicine was conferred upon him in 1931 by the Tulane University of Louisiana School of Medicine. His fraternities were Pi Kappa Alpha and Chi Phi.

Dr. Granade served at Fort Moultrie, S. C., and after graduation from the Medical Field Service School, served at Fort Oglethorpe, Ga. He was stationed in the Philippine Islands and Hawaii, and served with distinction in World War II in the Pacific Theater from Guadalcanal to the Philippines again. He held the Legion of Merit and Bronze Star Medal with oak leaf cluster.

After retiring as chief of medical service at Fort Benning, Ga., in 1947, Dr. Granade came to Bradenton to reside and engaged in the general practice of medicine there until he became ill two weeks before his death.

Dr. Granade was a member of the Manatee County Medical Society and for six years had held membership in the Florida Medical Association. He was also a member of the American Medical Association.

Surviving are the widow, Mrs. Lois C. Granade, and two daughters, Shirley and Gail Granade, all of Bradenton.

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Auxiliary Adds New Projects Each Year

As each new year of the Woman's Auxiliary to the Florida Medical Association starts, we find new projects and new ideas being added to the many projects and ideas already being carried out by the Auxiliary. The list of extra-scientific work done by the Auxiliary grows and grows and with each one added, the Auxiliary adds to its usefulness as an auxiliary, to the organized medical profession, and to the communities and the state.

In 1953-54 a chairman for the American Medical Education Foundation was appointed for the first time, and through the coordinated efforts of the county auxiliaries we saw our contributions more than double to this worthwhile, positive approach to government encroachment on education. The total contributions from Florida to the American Medican Education Foundation in the previous year, the first year the auxiliaries throughout the state were apprised of this need, was approximately $400. Last year, with a chairman

coordinating the work of receiving contributions from our county auxiliaries, we reached $1,075. This year Mrs. Lucien Y. Dyrenforth of Duval County, who raised $600 in the Duval County Auxiliary last year for AMEF, heads our state committee, and we have set a goal of $1.00 per member. This would make our contribution no less than $1,455.

The Woman's Auxiliary to the American Medical Association organized at the national level last year, for the first time, the Committee on Mental Health. Since their meeting always follows that of the Woman's Auxiliary to the Florida Medical Association, no chairmanship was set up in our State Auxiliary. However, under the leadership of Mrs. William D. Rogers of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Auxiliary as state project chairman, we had voluntary contributions from our component auxiliaries of over $600. With this we purchased the physical needs of a two-chair beauty shop which is now in use at the new Women's Receiving Hospital at the Florida State Hospital at Chattahoochee. A full time beauty operator has been employed by the hospital, and the patients help her in the work of this beauty shop. The morale of the patients has been definitely helped, and the beauty shop has become another effort toward occupational therapy in the treatment of the mentally ill.

This year, Mrs. Charles A. Brown of the Volusia County Auxiliary heads a new committee on Mental Health in our State Auxiliary. A beginning program has been set up for county auxiliaries to follow, but due to the fact that this project is new in the Auxiliary, we are hoping to go slowly and build our project slowly but soundly. During the year, county auxiliaries will study the facilities and personnel available at the community level and try to find out what happens to the mentally ill and mentally retarded in their own community. In some instances where such a study has already been done by another group and has been kept up to date, the auxiliary will get copies of such a study and inform themselves through it. In other counties where no study has been done, the auxiliary will endeavor to do such a study and make it available to the citizens of their community.

The second and third features of this new project will have to do with the collection of material things which can be used by or for the patients. Many small needs of the occupational therapy departments of the Florida State Hospital and the Florida Farm Colony are to be collected, such as scraps of material for quilt making, yarn and old hose for knitting and weaving purposes, used musical instruments for band or orchestra, records for victrolas, etc. A complete list of such things that can be used is being sent through the state chairman to each county auxiliary.

Starting several years back, many county auxiliaries sent Christmas gifts to these institutions for those patients who did not receive gifts from any other source, and under a coordinated program this Christmas Gift Project will be carried on again this year. Lists of things which can be sent will be sent by the state chairman to all county auxiliaries.

By the service it gives, the Auxiliary continues to grow and to become an important factor in community and state life. By its growth and service it helps organized medicine in its extra-scientific functions.

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BOOKS RECEIVED

What You Should Know About Mental Illness. By Orin Ross Yost, M.D. Pp. 165, Price, $3.50. New York, Exposition Press, 1953.

Of the more than three and a half million babies born in this country every year, at least 175,000 will at some time be confined in a mental hospital. An even greater number will be mentally ill for a long or short period, and few will go through life without being brought into close contact with someone who is mentally ill. That is the prospect, according to the author of this book, unless "the same effort and time and money are put into preventing mental illness that have been put into combatting those other diseases that once threatened the well-being of the newborn."

Dr. Yost, a distinguished psychiatrist of wide experience, who now resides in Ormond Beach, observes that few members of our modern, complex society are entirely free from the burden of tension and anxiety. Therefore, the more the general public understands the effects of everyday problems on the mind, the better they will be able to face them. In this book he outlines the knowledge that has been amassed concerning mental illness and related maladies — of which alcoholism is the most prominent. More important, by encouraging a "feeling" for psychiatry, he is able to explain, in lay terms, the part played by the subconscious mind in determining the form and adequacy of the individual's adjustment to society and to himself. The book is attractive to the general public because in simple language he elucidates the whys and wherefores of emotional conflicts and offers most helpful advice towards the achievement of smoother, happier living. Here is found instruction and guidance for those who seek understanding of the many problems and questions that beset the human mind in its constant struggle to adapt to increasingly complex situations.

A Doctor Talks to Women. By Samuel Raynor Meaker, M.D. Pp. 231. Price, $3.95. New York, Simon and Schuster, 1954.

This clearly written, informative and interesting book is designed to be helpful to intelligent women who want to learn about the working of their bodies, and in particular of their reproductive organs, in health and in disease. Out of his 30 years' experience as one of the country's leading gynecologists, Dr. Meaker has assembled in this volume the answers to the questions women most frequently ask a doctor about the special problems of their sex. With the warmth and humanity essential to an excellent physician, he speaks to them authoritatively on the anatomy, physiology and pathology of their reproductive organs. Many physicians will find this an excellent book to recommend to their patients.

The chapter headings include: The Womb and the Woman; The Female Organs of Reproduction; The Functions of the Ovaries; Normal Menstruation; The Change of Life; Absent or Insufficient Menstruation; Abnormal Bleeding; Painful Menstruation; Conception and the Beginning of Pregnancy; Fertility and Sterility; Help for Childless Couples; Ways in Which Early Pregnancy May Go Wrong; The Sex Relation; Planned Parenthood; Imperfect Development of the Female Organs; Injuries and Displacements; Leucorrhea; Infections and Inflammation; Cancer; Benign Tumors; The Bladder and the Rectum; The Breasts; Operations; X-rays and Radium; Douches; Treatment with Hormones; The Mind Can Influence the Body; An Ounce of Prevention; and The Womb, the Woman, and the World.

In the preface, Dr. Meaker, who is Professor Emeritus of Gynecology at the Boston University School of Medicine, writes: "The growing popular interest in medical matters is a good thing. It leads people to acquire useful new knowledge and to discard the old fallacies. Moreover, physicians find it easier to take care of well informed patients." This book should be helpful to many.



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ORIGINATORS OF CLINIC DROPPER

Salt and the Heart. By E. T. Yorke, M.D. Pp. 83. Price, $3.45. Linden, N. J., Drapkin Books, 1953.

Man can cope with his perversion for salt until he shows a tendency to accumulate it in any one of several conditions, particularly heart failure, a common problem afflicting the young or the old without causing sudden death. The author begins his book with a narrative on the "Old Salt," a retired sea captain, to describe one type of patient no longer capable of tolerating uncontrolled salting of food. Also typical are the beliefs entertained by the sea captain regarding the body's need for salt.

The principal theme of the book is concerned with the well known measures employed by physicians to combat salt accumulation in heart failure. Control of salt and sodium in foods offers the best results, according to Dr. Yorke, because it is the most natural means. Salt storage in pregnancy and notions on salt in obesity are also discussed. The reader will be surprised at the wide range of foods acceptable on the low sodium diet. Dr. Yorke has presented his material with such clarity that anyone can now learn how to control sodium in foods to any desired level, according to the decision of the physician.

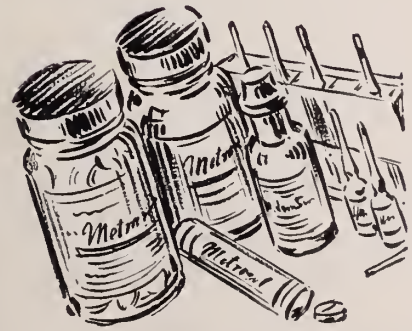
"The Pre-Adolescent Exceptional Child." Proceedings of the 35th Conference of the Child Research Clinic of The Woods Schools, Philadelphia, May 23, 1953.

This 70 page pamphlet is the second of a series of conference reports on medical and psychologic diagnosis, care, treatment and training, and education and social adjustment problems of the mentally retarded, emotionally disturbed child, from birth through adolescence. Papers published in this report of the complete proceedings of the conference held last May on the training and education of the retarded child are: "Diagnosis of Various Syndromes of the Retarded Child," by Dr. Archie A. Silver, Bellevue Hospital, New York; "Treatment of the Mentally Retarded Child" by Dr. Gale H. Walker, superintendent of Polk State School, Polk, Pa.; "Treatment of the Emotionally Disturbed Child," by Dr. Leon Eisenberg, Harriet Lane Home, Johns Hopkins Hospital, Baltimore; and a panel discussion on "What's Ahead for the Retarded Child and His Parents."

The pamphlet may be obtained without charge from the Child Research Clinic of The Woods Schools, Langhorne, Pa. A third conference in the series, on "Treatment and Training of the Adolescent Retarded Child," was scheduled for New Orleans, April 9 and 10, 1954.

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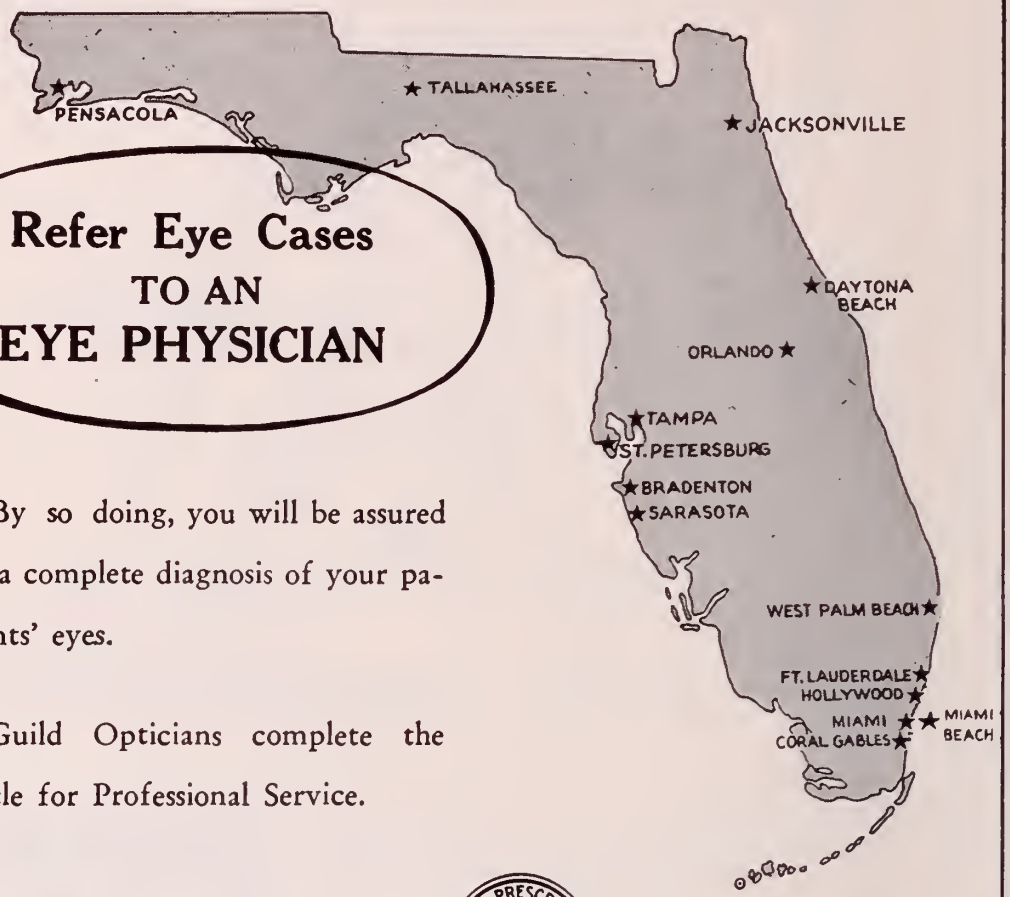
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On the basis of this study a dietary plan recommended for treatment of gastrointestinal disorders provides at least one gram, of protein per kilogram of body weight, but preferably more. Meat constitutes one of the important sources of animal protein in the plan.

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*Kirsner, J. B.; Brandt, M. B., and Sheffner, A. L.: Diet and Amino Acid Utilization in Gastrointestinal Disorders, J. Am. Dietet. A. *29*:1103 (Nov.) 1953.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



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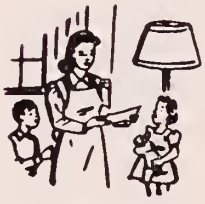
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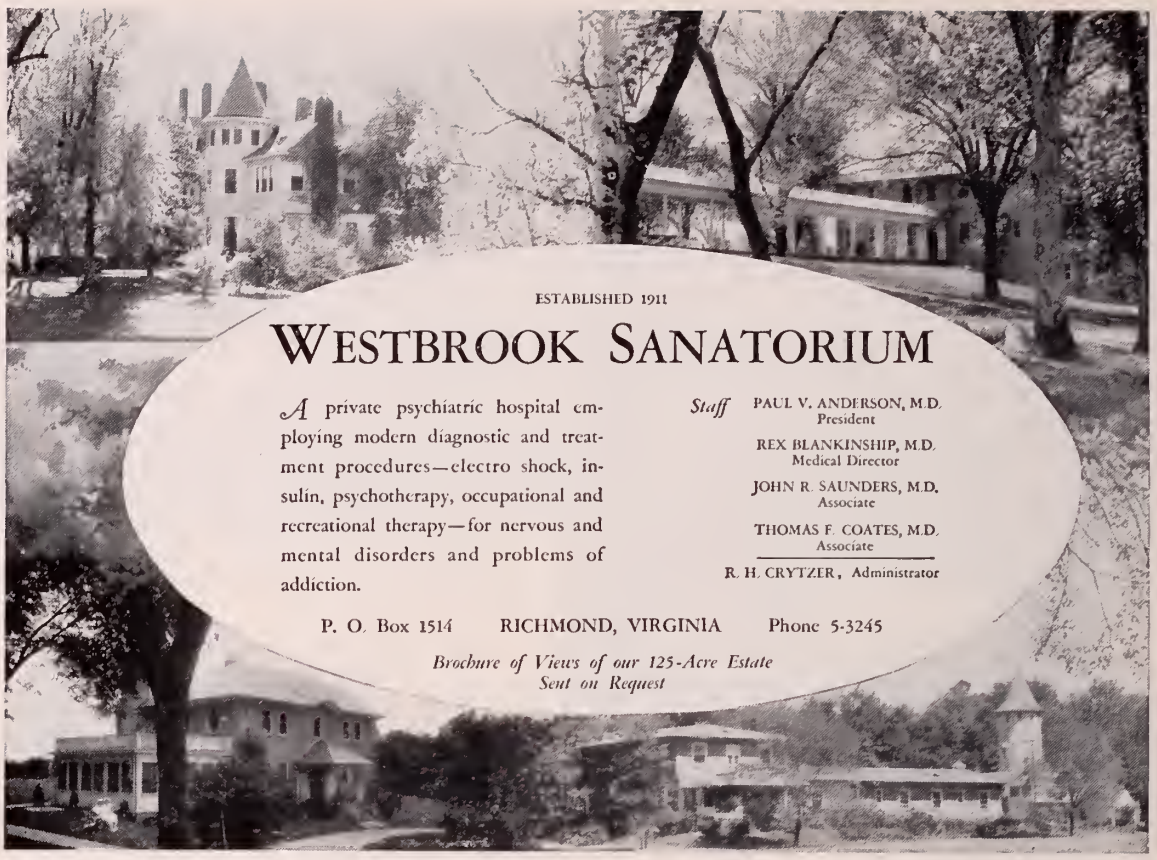
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
edical Association	Duncan T. McEwan, Orlando	Samuel M. Day, Jacksonville	St. Petersburg, Apr. 3-6, '55
edical Districts	Francis H. Langley, St. Petersburg	Council Chairman	
nwest	William H. Hixon, Pensacola	George S. Palmer, Tallahassee	Marianna, Oct. 11, '54
neast	Henry J. Babers Jr., Gainesville	Thomas C. Kenaston, Cocoa	Sanford, Oct. 13, '54
nwest	James R. Boulware Jr., Lakeland	Clyde O. Anderson, St. Petersburg	Sarasota, Oct. 15, '54
neast	James R. Sory, West Palm Beach	Russell B. Carson, Ft. Lauderdale	Vero Beach, Oct. 14, '54
ecialty Societies			
of General Practice	Leonard L. Weil, Miami Beach	Leon S. Eisenman, Hialeah	St. Petersburg, Apr. 3, '55
ciety	Solomon D. Klotz, Orlando	Edwin P. Preston, Miami	" "
logists, Soc. of	R. Gaylord Lewis, West Palm Beach	Harry E. Bierley, West Palm Beach	" "
s., Am. Coll., Fla. Chap.	DeWitt C. Daughtry, Miami	Jack Reiss, Coral Gables	" "
a Syph., Soc. of			" "
Cicers' Society	Thomas E. Morgan, Jacksonville	Lorenzo L. Parks, Jacksonville	" "
and Railway Surgeons	Plumer J. Manson, Miami	John H. Mitchell, Jacksonville	" "
& Psychiatry	Sullivan G. Bedell, Jacksonville	Roger E. Phillips, Orlando	" "
ynec. Society	Harold G. Nix,Tampa	Reuben B. Chrisman Jr., Miami	" "
Otol., Soc. of	G. Tayloe Gwathmey, Orlando	Carl S. McLemore, Orlando	" "
c Society	John F. Lovejoy, Jacksonville	Newton C. McCollough, Orlando	" "
ts, Society of	Millard B. White, Sarasota	James B. Leonard, Tampa	" "
ociety	C. Jennings Derrick, W. Palm Bch.	Wesley S. Nock, Coral Gables	St. Petersburg Bch., Oct. 22-24, '54
c Society	Claude G. Mentzer, Miami	George Williams Jr., Miami	St. Petersburg, Apr. 3, '55
al Society	A. Judson Graves, Jacksonville	James T. Shelden, Lakeland	" "
Am. Coll., Fla. Chapter	Frederick J. Waas, Jacksonville	C. Frank Chunn, Tampa	" "
ic Society	Linus W. Hewit, Tampa	Frank J. Pyle, Orlando	" "
-			
ience Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	
danks, Association	John T. Stage, Jacksonville	John B. Ross, Jacksonville	St. Petersburg, 1955
oss of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	Palm Beach Shores, Nov. 17, '54
eld of Florida, Inc.	David R. Murphey Jr., Tampa	Jack O. W. Rash, Miami	
Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	St. Petersburg, Apr. 3, '55
Diabetes Assn.	Fred Mathers, Orlando	Edward R. Smith, Jacksonville	Orlando, Oct. 21-22, '54
ociety, State	Robt. Thoburn, D.D.S., Daytona Bch	J. E. Edwards, D.D.S., Coral Gables	Jacksonville, Apr. 23-25, '55
ssociation	Alvin E. Murphy, Palm Beach	Daniel R. Usdin, Jacksonville	
il Association	Mr. J. F. Wymer Jr., W. Palm B.	Mrs. Mary Reeder, Miami	
ic Examining Board	Amsie H. Lisenby, Panama City	Homer L. Pearson Jr., Miami	
ic Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, July 12-16, '54
nesthetists, Fla. Assn.	Miss Dorothy Jackson, C. Gables	Mrs. Lulla F. Bryan, Miami	
Association, State	Mrs. Bertha King, Tampa	Mrs. Idalyn Lawthon, Tampa	November '54
ceutical Association, State	Mr. J. L. McDonald, St. Augustine	Mr. R. Q. Richards, Ft. Myers	Clearwater, May '55
ic Health Association	Frank M. Hall, Gainesville	Mr. Fred B. Ragland, Jacksonville	Miami Beach, Oct. '54
ic Society	Lawrence C. Manni, Tallahassee	Simon D. Doff, Jacksonville	
r losis & Health Assn.	Judge Ernest E. Mason, Pensacola	Mrs. L. C. Conant, Fort Myers	
s Auxiliary	Mrs. Richard F. Stover, Miami	Mrs. S. J. Wilson, Ft. Lauderdale	St. Petersburg, Apr. 3, '55
a Medical Association	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	Atlantic City, June 6-10, '55
A Clinical Session	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	Miami, Nov. 29-Dec. 2, '54
n Medical Association	Alphonse McMahon, St. Louis	Mr. C. P. Loranz, Birmingham	St. Louis, Nov. 8-11, '54
a Medical Association	J. M. Donald, Birmingham	Douglas L. Cannon, Montgomery	Montgomery, Apr. 21-23, '55
a Medical Assn. of	Peter B. Wright, Augusta	David Henry Poer, Atlanta	Augusta, May 1-4, '55
b ital Conference	Mr. John W. Gill, Vicksburg, Miss.	Mr. Pat Groner, Pensacola	Atlanta, Apr. 20-22, '55
a rn Allergy Assn.	W. L. Rucks, Memphis, Tenn.	Kath. B. MacInnis, Columbia, S. C.	
a rn, Am. Urological Assn.	Sam L. Raines, Memphis, Tenn.	Robert F. Sharp, New Orleans	New Orleans Mar. 20-23, '55
a rn Surgical Congress	J. Duffy Hancock, Louisville, Ky.	B. T. Beasley, Atlanta	Atlanta, Mar. 7-10, '55
a Clinical Society	Jas. N. Lockard, Pascagoula, Miss.	F. C. Minkler, Pascagoula, Miss.	Edgewater Park, Miss., Oct. 21-22, '54

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County Medical Societies of Florida

SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Total Members
Alachua	Henry H. Graham, Gainesville	Glenn O. Summerlin, Gainesville	2nd Tues.	51
***Bradford, Gilchrist, Union**				
Bay	Lemuel F. Coxe Jr., Panama City	James D. Nixon, Panama City	1st Tues.	26
Brevard	Theodore J. Kaminski, Melbourne	Paul L. Summers, Melbourne	2nd Tues.	28
Broward	Julius F. Boettner, Fort Lauderdale	George T. F. Rahilly, Fort Lauderdale	4th Tues.	108
Columbia	Robert B. Harkness, Lake City	Thomas H. Bates, Lake City	1st Mon.	12
***Baker, Hamilton**				
Dade	Edward W. Cullipher, Miami	Kenneth S. Whitmer, Miami	1st Tues.	667
DeSoto-Hardee-Highland-Glades	Carl J. Larsen, Avon Park	Samuel A. King, Avon Park	2nd Tues.	27
Duval	Karl B. Hanson, Jacksonville	Jackson L. Allgood Jr., Jacksonville	1st Tues.	272
***Clay**				
Escambia	Wilton E. Tugwell, Pensacola	Paul F. Baranco, Pensacola	2nd Tues.	96
***Santa Rosa**				
Franklin-Gulf	Albert L. Ward, Port St. Joe	Warren T. Weathington, Apalachicola	Last Wed.	9
Hillsborough	C. Frank Chunn, Tampa	Julien C. Pate Jr., Tampa	1st Tues.	179
Indian River	William L. Fitts 3rd, Vero Beach	Vernon L. Fromang, Vero Beach	2nd Tues.	10
Jackson-Calhoun	Jabe A. Breland, Marianna	Francis M. Watson, Marianna	Quarterly	18
Lake	J. Basil Hall, Tavares	James R. Hanson, Tavares	1st Wed.	28
***Sumter**				
Lee-Charlotte-Collier-Hendry	H. Quillian Jones, Fort Myers	James L. Bradley, Fort Myers	3rd Mon.	37
Leon-Gadsden-Liberty-Wakulla-Jefferson	George H. Massey, Quincy	Odis G. Kendrick Jr., Tallahassee	Quarterly	57
Madison	Wallace E. Winter, Madison	Julian M. DuRant, Madison		4
Manatee	Willett E. Wentzel, Bradenton	Marjorie L. Warner, Bradenton	2nd Tues.	24
Marion	William H. Anderson Jr., Ocala	Bertrand F. Drake, Dunnellon	3rd Tues.	30
***Levy**				
Monroe	Edward Gonzalez, Key West	Herman K. Moore, Key West	2nd Thurs.	12
Nassau	David G. Humphreys, Fernandina	John W. McClane, Fernandina	Last Fri.	11
Orange	Eugene L. Jewett, Orlando	Andrew W. Townes Jr., Orlando	3rd Wed.	182
***Osceola**				
Palm Beach	Thomas E. Daly, West Palm Beach	David A. Newman, Palm Beach	3rd Mon.	132
Pasco-Hernando-Citrus	Frank Y. Robson, New Port Richey	W. Wardlaw Jones, Dade City	2nd Thurs.	18
Pinellas	Alvin L. Mills, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	217
Polk	Theodore C. Keramidas, Winter Haven	James T. Shelden, Lakeland	2nd Wed.	91
Putnam	Lawrence G. Hebel, Palatka	James A. Long Jr., Palatka	2nd Tues.	10
St. Johns	James J. DeVito, St. Augustine	Reuben J. Plant Jr., St. Augustine	3rd Tues.	19
St. Lucie-Okeechobee-Martin	Laurance D. Van Tilborg, Ft. Pierce	Adrian M. Sample, Fort Pierce	3rd Thurs.	20
Sarasota	Henry J. Vomacka, Sarasota	Lloyd J. Duest, Sarasota	2nd Tues.	52
Seminole	J. Clifford Boyce, Sanford	Terry Bird, Sanford	2nd Tues.	18
Suwannee	William P. Blackmon, Mayo	Hiram B. Curry, Jasper	1st Sat.	9
Taylor	George H. Warren, Perry	Walter J. Baker, Foley	Last Fri.	6
***Dixie, Lafayette**				
Volusia	Cleland D. Cochrane, Daytona Beach	Robert L. Miller, Daytona Beach	2nd Tues.	85
***Flagler**				
Walton-Okaloosa	Robert von P. Maxon, Fort Walton	Arthur G. Williams Jr., Valparaiso	3rd Thurs.	20
Washington-Holmes	Ralph H. Segrest, Bonifay	Bayllye W. Dalton, Chipley		6
			Total,	2,590

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1. Cook, M. H.; Free, A. H., and Giordano, A. S.: Am. J. M. Technol. *19*:283, 1953.
2. Gray, C. H., and Millar, H. R.: Brit. M. J. *4824*:1361 (June 20) 1953.

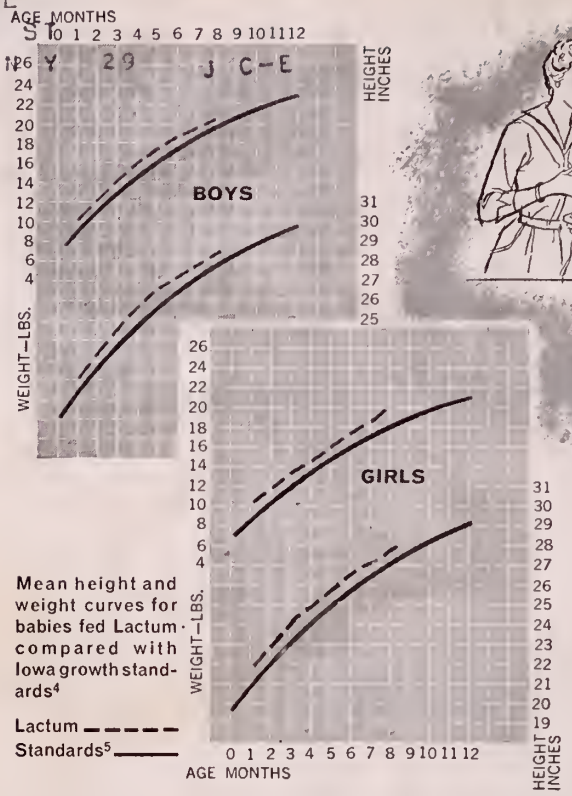
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(1) Jeans, P. C.: In A.M.A. Handbook of Nutrition, Ed. 2, Philadelphia, Blakiston, 1951, p. 275. (2) Albanese, A. A.: Pediat. 8: 455, 1951. (3) Holt, L. E., Jr., and McIntosh, R.: In Holt Pediatrics, Ed. 12, New York, Appleton-Century-Crofts, Inc., 1953, pp. 175-178. (4) Frost, I. H., and Jackson, R. L.: J. Pediat. 39: 585, 1951. (5) Jackson, R. L., and Kelly, H. G.: J. Pediat. 27: 215, 1945.

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OCTOBER 11 - 15, 1954

IN THIS ISSUE

Inoperable Prostatic Carcinoma
Louis M. Orr, James L. Campbell Jr., and Miles W. Thomley

Conquest of Pain
C. MacKenzie Brown

Creeping Eruption
Wiley M. Sams and Hollis F. Garrard

Bronchial Adenoma and Lung Cancer
Ivan C. Schmidt

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1. Parsons, L., and Tenney, B., Jr.: M. Clin. North America *34*:1537, 1950.
2. Greenblatt, R. B.: J. Clin. Endocrinol. & Metab. *13*:828, 1953.

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1. Werner, A.: Acta endocrinol. *13*:87, 1953.
2. Malleson, J.: Lancet *2*:158 (July 25) 1953.
3. Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc., 1953, p. 23.

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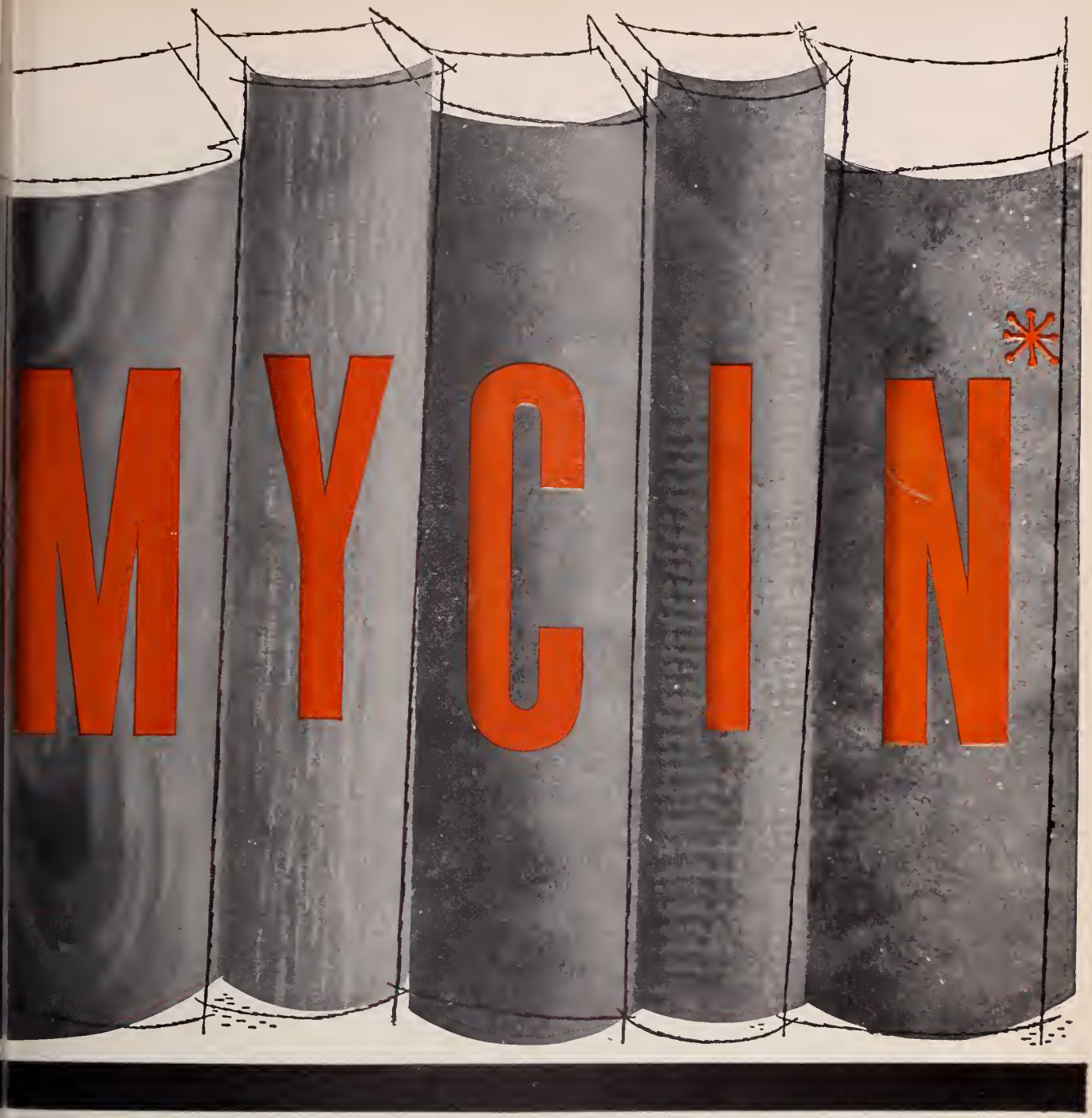




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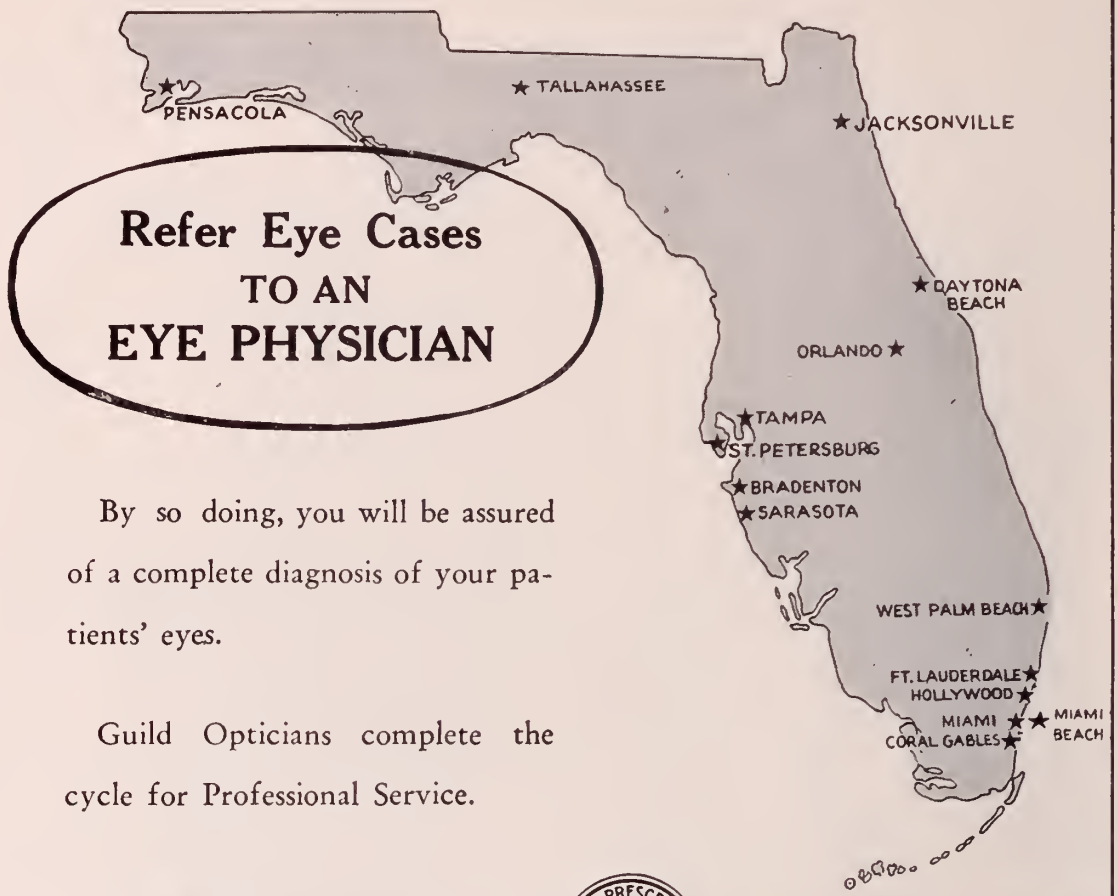
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1 Abel, M.S., Lomhoff, I.I., and Garcia, C.V.: Permanente Found. Med. Bull., 10:95, Aug., 1952.
2 Lowman, R.M., and Stanley, H.W.: Connecticut Med. Jour., 16:591, Aug., 1952

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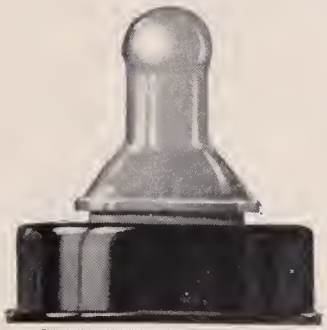
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The Treatment of Inoperable Prostatic Carcinoma With Au 198

Louis M. Orr, M.D.
James L. Campbell Jr., M.D.
AND
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ORLANDO

Cancer of the prostate is considered the most common malignant disease occurring in men after the age of 60 and probably occurs in 20 per cent of all men past that age. In routine autopsy studies six pathologists found small latent foci of prostatic carcinomas in 14 to 46 per cent of men over the age of 50. Ten per cent of routine benign prostatic specimens, when rechecked and intensively examined, also were found to be malignant. With the increase in life expectancy, physicians have become more respectful of this malignant lesion of the aged since its frequency will, no doubt, increase with longevity.

The cause of cancer of the prostate is unknown although it would certainly appear to be the result of some chemical or hormonal imbalance. It is generally agreed that 90 per cent of prostatic carcinomas originate in the posterior lobe. The lesion is slow-growing and usually metastasizes late. For this reason carcinoma of the prostate is asymptomatic until extension beyond the confines of the capsule, or distant spread, has occurred.

The imperativeness of rectal examination cannot be overemphasized since digital palpation is the most valuable single diagnostic factor in detecting early cancer of the prostate. It has been estimated that one can diagnose accurately benign prostatic hypertrophy in 96 per cent of all cases and carcinoma in 88 per cent by rectal examination.

Read before the Florida Medical Association, Eightieth Annual Meeting, Hollywood, April 26, 1954.

It is generally agreed that early prostatic carcinoma should be treated by radical prostatectomy. Patients between 75 and 80 years of age, whose life expectancy is only a few years, possibly should not be subjected to radical prostatectomy for they do not tolerate the procedure well at this age. It has been estimated that only 5 to 10 per cent of prostatic carcinomas are diagnosed sufficiently early to be cured by radical surgery. This small percentage is the result of (1) the failure of early prostatic carcinoma to produce symptoms, (2) the failure of the examiner to perform rectal examinations, and (3) the failure of male patients to seek voluntarily periodic rectal examinations.

Over 150 years ago John Hunter observed that castration produced atrophy of the normal prostate gland, and in the latter part of the nineteenth century White reported that castration was of benefit in 85 per cent of the patients with obstructive prostatism. It has been only in the past 15 years, however, that endocrine therapy of the prostatic cancer has been introduced and developed.

The first reports of estrogenic management of prostatic carcinoma were made by Huggins, Scott and Hodges[1] in 1941. At about this time Munger[2] used external radiation to decrease the androgen factors in the treatment of prostatic malignant disease. In 1945 Herbst[3] and in 1947 Sauer[4] introduced radiation of the pituitary and Huggins and Scott[5] observed the effect on prostatic car-

cinoma by removing the adrenal and pituitary glands.

One of the most important factors to consider in inoperable carcinoma of the prostate is the patient's age. With the male population attaining an age which is greater today than ever before, urologists are seeing more men with advanced cancer of the prostate. Insurance charts show that life expectancy for a 75 year old man is six years. Since the life span has been increased, we are striving to afford the increasing number of patients afflicted with prostatic malignant disease longer and more comfortable survival periods. It is interesting to evaluate just how much increase in longevity can be claimed from purely medical treatment.

Nesbit and Plumb[6] in 1946 reported that in 795 cases of untreated prostatic carcinoma the average period of survival from the time of diagnosis was 21.2 months. In a series of 485 cases presented by Bumpus[7] the survival time was 31 months. Estrogenic therapy was not employed in these cases. The survival period at the present time, by utilization of all forms of palliative therapy, has increased only an additional nine to 18 months.[8] This slight additional period makes us wonder whether the increase is real or merely apparent, since it would appear logical to assume that we are, undoubtedly, seeing prostatic carcinomas earlier today than a few years ago. It is entirely possible that the increase in survival time may be in direct proportion to the increased interest in geriatrics and improvement in general care of the aged.

That estrogenic therapy, despite its widely heralded virtues, has really contributed so little to the increase in survival time of the patient with inoperable cancer of the prostate is, to say the least, surprising and, at the same time, disappointing. It was no doubt a realization of this fact that prompted Flocks[9] in 1951 to be the first to instill a radioactive isotope, Au 198, into the prostate gland of patients with hopeless carcinoma of that organ. Since the original report[9] he and his associates have reported on more than 200 patients treated by this method. His results have been sufficiently encouraging to stimulate other investigators along the same lines of endeavor.

It was determined years ago that irradiation with the roentgen ray or radium was ineffective in the treatment of cancer of the prostate. The question which immediately arises is why would the use of a radioisotope be more effective than roentgen therapy or radium.

Isotopes have several unique properties not possessed by the roentgen ray, radium, radon, or even cobalt as presently employed. Most important of these is that an isotope is a form of radiation suspended in a solution as a stable colloid containing millions of small particles. These small particles represent multiple point sources of radiation which are separated by varying distances.

Au 198 was selected as the most suitable isotope for use in prostatic cancer because of its stability, its favorable half life of 2.7 days, its relative uniformity in arrangement of its molecular pattern, its proportion of gamma and beta radiation and its relatively low cost of production.

Problem of Dosage

In the use of any radioactive isotope, which is injected interstitially for the treatment of cancer, the problem is not simply one of how many millicuries to use but rather how the radioactive material is distributed throughout the tumor and how long it remains at the site of the injection.

The cancerocidal dose in terms of roentgens delivered to the tumor has been fairly well determined in the case of most tumors by years of treatment with radium and roentgen ray, and it has been shown that optimal results are obtained by using a dose which falls within fairly narrow limits. *Under*dosage results in a therapeutic failure whereas *over*dosage may actually decrease rather than increase the rate of cure and produce many undesirable sequelae and complications. Although this dosage can be rather simply determined with the roentgen ray, the problem is much more complex in the case of interstitially injected radioactive isotopes. The dosage received from beta and gamma radiation is easy to calculate if it is assumed that there is an absolutely uniform distribution of the isotopes throughout the tumor, provided the exact size and volume of the tumor are known. Unfortunately, these ideal conditions never occur in actual use. The problem then, in reality, is trying to determine the varying doses in different parts of the injected tissue since it is not the average dose which is of interest but rather the maximum and the minimum doses.

In the use of radioactive gold interstitially, the problem of radiation dosage is that of gamma and not beta dosage. At first glance, this statement seems rather surprising in view of the fact that the beta radiation is roughly 10 times greater than

the gamma rays, if one assumes an equal distribution throughout the tissues. Since gold does not have a homogenous distribution, the radiation must be computed from multiple point sources of radiation which are separated by varying distances. The beta particles of radioactive gold have an effective range of only 1 mm., and any tumor cells not within 1 mm. of the radioactive gold would be unaffected by this radiation. The effect would be that while some of the cells would be intensely irradiated by beta particles, other tumor cells would receive no radiation whatsoever. With gamma radiation the dosage also drops off fairly rapidly from a point source due to the inverse square law. With multiple point sources there is cross firing of tumor cells from many different points of radiation with the result that all of the tissue is irradiated although there may be a difference of more than 100 per cent between the minimum and the maximum dose, assuming that the point sources are not separated by a distance of more than 5 mm. If the distance between the point sources is greater than 5 mm., the difference between the minimum and maximum dose will be much greater and a point is finally reached where portions of the tumor are receiving less than a cancerocidal dose.

In order to diminish the difference between the minimum and maximum dose, it is necessary to produce as uniform a distribution of the isotope as possible in the injected tissues. Having determined the most desirable volume, how many millicuries should be used in order that the minimum dose will approach the known cancerocidal dose and the maximum dose will not be large enough to produce undesirable sequelae?

The importance of knowing these factors must be self evident since the results to be obtained in treating patients with carcinoma of the prostate will depend to a large extent on how carefully the radiation is administered. These factors can be determined experimentally, although they have not been, up to the present time. By obtaining injected material from both man and animal, it would be possible by radioautograph to determine the distribution of the gold, and the variation in dosage received by different portions of the prostate could be determined by making multiple radio assays of different portions of the prostate.

Indications and Contraindications for Use of Au 198

The best chance of cure of cancer of the prostate, which is confined within the capsule of the gland, is total prostatectomy including removal of the seminal vesicles. The use of radioactive isotopes in such a condition is definitely contraindicated. Evidence of spread of the cancer beyond the area of the prostate and its immediately contiguous structures, as determined by elevation of the serum acid phosphatase, physical examination, or bony metastases, precludes the usefulness of interstitial radiation with an isotope. The general condition of the patient and any serious complicating illnesses must also be considered before using this type of therapy.

Discussion of Cases

Our results in the treatment of 26 consecutive cases of advanced carcinoma of the prostate with Au 198 have been for the most part highly encouraging (tables 1 and 2). The earliest cases of any series are as a rule subject to the greatest complications and the poorest results. Conversely, as the technic is improved and selection of cases is better, the end result becomes more gratifying. In our series there was a total of 4 deaths, and these occurred in the first 6 cases (table 3). Likewise, almost all the serious complications arose in the first 10 cases (table 4). In cases presently treated serious complications are practically nonexistent.

In describing the local changes that take place in many extensive, large, stony-hard prostates, one must exercise restraint for fear of being too enthusiastic. As a rule, however, the entire area undergoes a softening and shrinking process that results in a flat or even concave prostatic bed. Many of these have already had the benefit of previous estrogenic therapy and either they have failed to respond to it or the carcinoma has been reactivated. Not only has an atrophy of a large percentage of viable tumor tissue taken place, but the chance of early metastasis has been minimized by the pick-up of the beta particles in the lymph vessels draining the area.

The average age of the patients in our series was 68.8 years with the youngest being 52 and the oldest 81. Estimates of the size of each prostate were attempted preoperatively, and the average of these estimations was 32 Gm. The dosage of Au 198 delivered into each gland was generally

based on its size and the amount of tumor present. The average dose given per operation was 90.3 millicuries. In view of the average size this gives an average ratio of 2.1 millicuries per gram of tissue, which is higher than the reported optimum dosage. The largest dosage to any one patient was 200 millicuries; however, this was delivered in two separate operations with an interval of five and a half months intervening. The largest dosage given at a single operation was 145 millicuries and the smallest 25 millicuries.

One of the many advantages of this type of therapy is the ease with which additional Au 198 can be injected perineally as nodules or areas of hardness develop. As many as 5 to 7 cc. of colloidal gold may be injected through spinal needles through the perineum with no ill effects. This method has been employed on four occasions with good results.

Some pertinent remarks about individual cases may prove to be of interest:

Table 1.—Results of Treatment with Au 198 in 26 Cases of Inoperable Prostatic Carcinoma

Case No.	Age	Serum Acid Phosphatase	Size of Prostate	Dosage of Au 198	Results
1	56	4.0	++	40 RP* 10 Pr†	Fair
2	52	3.1	+	8 RP 5 Pr	Expired
3	73	5.3	++++	112.5 RP 20 Pr	Expired
4	65	6.5	++	40 RP None	Expired
5	81	3.7	+	75 RP None	Good
6	75	6.0	++++	145 RP None	Expired
7	80	3.0	+	45 RP None	Excellent
8	67	1.4	+++	55 RP None	Excellent
9	67	4.5	+++	100 RP None	Expired
10	66	2.2	++	75 RP None	Excellent
11	78	6.5	+++	75 RP None	Fair
12	75	2.3	+++	85 RP None	Fair
13	65	3.0	+++	70 RP 10 Pr	Good
14	76	1.0	++	90 RP 10 Pr	Excellent
15	67	2.0	+++	85 RP 20 Pr 95 Pr‡	Poor
16	58	3.0	+++	90 RP 10 Pr	Excellent
17	74	2.0	+++	80 RP 10 Pr	Excellent
18	75	1.5	+++	100 RP 10 Pr	Excellent
19	55	1.6	+++	95 RP 20 Pr	Excellent
20	75	2.5	++	112 RP None	Excellent
21	69	2.2	+++	100 RP 15 Pr	Poor
22	68	3.4	++	108 RP 20 Pr	Excellent
23	68	1.2	None§	80 RP 15 Pr	Excellent
24	58	4.1	++	95 RP 20 Pr	Excellent
25	70	1.8	+++	85 RP 20 Pr	Excellent
26	67	3.6	+++	105 RP 20 Pr	Excellent

*Retropubic
†Perineum
‡Second admission — open perineal instillation
§Previous prostatoseminovesiculectomy.

In case 1 carcinoma was diagnosed in 1951, and treatment consisted of transurethral resection and orchiectomy. The acid phosphatase was 4.0 mg., but roentgen evidence of metastasis was lacking. In April 1953 the mass in the prostate had increased markedly with involvement of both vesicles. Au 198 was injected, and the result has been satisfactory. The prostatic mass has become smaller, but a hard ridge on the right has recently required 2 cc. of gold perineally. It has not completely disappeared although the patient has never felt better.

In case 8 there was obvious extracapsular carcinoma of the prostate in late 1951. Transurethral resection and orchiectomy were employed, and the patient was comfortable until May 1953 when the prostate became larger with increased hardness. Au 198 was injected retropubically in July with an excellent result. Convalescence was marred by a pulmonary embolus, which necessitated a caval ligation.

Table 2.—Analysis of Results According to Size of Neoplasm

Size of Neoplasm	Number of Cases	Died	Poor	Good	Excellent
+	4*	1 or 25%	—	1 or 25%	2 or 50%
++	7	1 or 14.3%	1 or 14.3%	—	5 or 71.4%
+++	13	1 or 7.7%	2 or 15.4%	3 or 23.1%	7 or 53.8%
++++	2	2 or 100%	—	—	—
	26	5	3	4	14

*Includes case 23 with previous prostatoseminovesiculectomy.

A massive carcinoma with involvement of the left seminal vesicle was present in case 5 in January 1953. Transurethral resection and orchiectomy were performed, and estrogenic therapy was given. In May 1953 Au 198 was injected retropubically, and the prostate has shrunk to normal size. The course has been complicated by a dense urethral stricture and the development of a calculus in the bladder. The calculus was recently removed, and progress is at present satisfactory.

The patient in case 10 has received wonderful results from gold therapy for a grade III carcinoma first diagnosed in 1949. He now has no palpable evidence of malignant disease of the prostate.

In case 11 the patient has been treated for grade III carcinoma since 1949 and recently required a perineal injection of gold into a small apical mass of tumor. Otherwise he appears in good health.

Table 3.—Analysis of Deaths

Case	Age	Remarks
2	52	Died third postoperative day—massive pulmonary embolus
3	73	Died fourth postoperative day—extensive metastasis to bone and soft tissues
4	65	Died 6 months postoperatively of generalized carcinomatosis
6	75	Died second postoperative day—extensive metastasis to liver
9	67	Died 5 months postoperatively of extensive metastasis

Table 4.—Complications

Total patients involved	8
Pulmonary emboli (one recovered)	2
Delayed wound healing	5
Rectal irritation with hemorrhage	2
Postoperative bladder calculi	2
Severe postoperative nausea	2
Urethral stricture	1

In case 7 the malignant lesion was diagnosed in September 1951 and was treated by orchiectomy, transurethral resection and estrogen therapy. Growth was retarded until May 1953 when the area became larger. Interstitial injection of Au 198 was accomplished in May 1953, and although the patient has not been seen recently, he is reported to be in good health and has lost no weight.

A large extracapsular grade II malignant lesion was present in 1949 in case 12, and in March 1953 the rectum appeared full of tumor. In August 1953 treatment with gold was administered, and at the present time the prostatic bed is concave except for a knot of tumor near the right apex. This will require some additional Au 198 perineally.

In case 13 the diagnosis in June 1952 was a hard fixed gland with most of the tumor in the left side of the prostate. This area was generously injected with gold in August 1953, and in October additional gold was injected into the right apex of the prostate. The original area of extensive tumor was completely free of malignant disease at that time. The present condition of the patient is excellent.

The patient in case 14 has received combined therapy for a grade III lesion, which was first treated in August 1953. He is in excellent health at present and has no palpable evidence of malignant disease of the prostate.

When the patient in case 15 was first seen in 1951, the prostate was large and grossly irregular. Transurethral resection and orchiectomy were not successful in effecting much improvement in the size of the malignant lesion. In October 1953 Au 198 was injected retropubically, and again there was little evidence of shrinkage. In January 1954 the area was exposed perineally, and 95 millicuries was injected. It is too early to determine results of the latest therapy.

In case 16 a large inoperable carcinoma with involvement of the right seminal vesicle was present in 1950. Combined therapy has given excellent results, with a flat prostatic bed. The patient has been distressed recently because of the formation of some encrustations in the neck of the bladder.

There has been a wonderful result in case 18, in which an extensive lesion involved the urethral sphincter. The patient was first seen in July 1953, and the combined therapy has been carried out.

The patient in case 19 was the youngest in the series, and the combined therapy has resulted in remarkable shrinkage of a large hard gland. Only four months postoperatively there is no palpable evidence of a tumor.

In case 20 there was the complication of a large tumor of the bladder in addition to a large prostatic malignant lesion. This was resected at the time of the instillation of the Au 198, and there has been no recurrence of either.

Little recession of the large tumor present in case 21 has resulted from the combined therapy. Obviously it will be necessary to inject considerably more Au 198 perineally.

Case 23 is one of the most unusual cases. The patient was subjected to radical prostatoseminovesiculectomy and orchiectomy in 1946. He had apparently been followed closely by his physician, and it was only in November 1953 that symptoms of prostatism recurred. Rectal examination revealed induration of the neck of the bladder and of the sphincter of considerable degree. Transurethral biopsy of a small amount of tissue revealed grade II adenocarcinoma of prostatic origin. This patient was given the largest per gram dosage of the series. There was pronounced regression of the induration within four weeks' time.

Delayed wound healing and prolonged suprapubic drainage of urine were the most frequent complication. All patients remained hospitalized until drainage had stopped. The average period of hospitalization was 22 days. The shortest period of hospitalization was 13 days. It is believed that the inflammatory reaction from radiation has a definite effect on wound healing, but there is apparently little relationship between the millicuries/gram ratio and wound healing. There were pulmonary emboli in 2 cases. The first occurred four days postoperatively and resulted in immediate death. The other occurred 27 days postoperatively in a patient in whom the healing process was slow and who simply would not move or get out of bed. Recovery was uneventful in the latter case.

Summary and Conclusions

A brief outline is presented showing why Au 198 is the isotope of choice at the present time in the treatment of inoperable prostatic carcinoma. The technic of instillation and a series of 26 cases are presented with a discussion of results obtained by retropubic and perineal instillation of Au 198.

Other subjects of great importance which have received little attention are: (1) Of the gold injected into the prostate, how much remains in the gland? How much is lost in the urine, through drainage at the operative site, through gold spilled and removed from the body in the operating room, and through gold which goes by blood stream to the liver? (2) How much gold goes to the adjacent lymph nodes, and is this amount sufficient to have a cancerocidal effect? Flocks,[10] as stated in a recent personal communication, is convinced that this effect is produced by Au 198. (3) What is the dosage received by the rectum, adjacent to the prostate, and how can this be reduced without affecting the treatment?

These are only a few problems that arise in connection with the use of interstitial gold therapy which must be solved. Solving them would materially improve the results obtained by treatment as well as eliminate, in so far as possible, undesirable radiation reactions.

References

1. Huggins, C.; Scott, W. W., and Hodges, C. V.: Studies on Prostatic Cancer; Effects of Fever, of Desoxycorticosterone and of Estrogen on Clinical Patients with Metastatic Carcinoma of Prostate, J. Urol. 46:997-1006 (Nov.) 1941.
2. Munger, A. D.: Experiences in Treatment of Carcinoma of Prostate with Irradiation of Testicles, J. Urol. 46:1007-1011 (Nov.) 1941.
3. Herbst, W. P.: Effects of Biochemical Therapeusis in Carcinoma of Prostate; Further Observations, J. A. M. A. 127: 57-59 (Jan. 13) 1945.
4. Herger, C. C., and Sauer, H. R.: Consideration of Effect of Androgen Control Treatment of Carcinoma of Prostate, New York State J. Med. 47:494-501 (March 8) 1947.
5. Huggins, C., and Scott, W. W.: Bilateral Adrenalectomy in Prostatic Cancer; Clinical Features and Urinary Excretion of 17-Ketosteroids and Estrogen, Ann. Surg. 122:1031-1041 (Dec.) 1945.
6. Nesbit, R. M., and Plumb, R. T.: Prostatic Carcinoma: Follow-Up on 795 Patients Treated Prior to Endocrine Era and Comparison of Survival Rates Between These and Patients Treated by Endocrine Therapy, Surgery 20:263-272 (Aug.) 1946.
7. Bumpus, H. C. Jr.: Transurethral Resection and Paraplegic, Tr. Am. A. Genito-Urin. Surgeons (1946), 38:283-289, 1947.
8. Glanton, J. B.; Fitzpatrick, R. J.; Orr, L. M., and Hayward, J. C.: Palliative Treatment of Prostatic Cancer, South. M. J. 45:1094-1099 (Nov.) 1952.
9. Flocks, R. H.; Kerr, H. D.; Elkins, H. B., and Culp, D.: Treatment of Carcinoma of Prostate by Interstitial Radiation with Radio-active Gold (Au 198): A Preliminary Report, J. Urol. 68:510-522 (Aug.) 1952.
10. Flocks, R. H.: Personal communication in March, 1954.

1300 Kuhl Avenue.

The Conquest of Pain

C. MacKenzie Brown, M.D.
TAMPA

The discussion of the next few minutes is for every practitioner of medicine because pain is universal and is the main reason why patients seek the aid of a doctor. Let us consider some of the painful diseases which may be helped or cured by nerve block therapy[1] or by the use of the hollow needle.[2]

The crux of this conquest of pain is accurate diagnosis. The physician must know its causes, variations and mechanisms, and also the physical and mental effects that it produces.[3] Most essential are a working knowledge of the regional anatomy and of the use of proper solutions and also adequate experience in the various technics. The sooner the pain syndrome is treated the better, before intractable changes have occurred.

Block the pain early. For example, in the patient afflicted by herpes zoster it is highly effective, specific therapy to block the involved posterior root ganglia with Pontocaine within the first few days of existence of the burning pain. For that victim in whom the pain is of several months' duration, unfortunately it is much more difficult to manage.

Read before the Florida Medical Association, Eightieth Annual Meeting, Hollywood, April 26, 1954.

Choice of Drugs

All the scientific endeavor of the past has not discovered the perfect drug which relieves all pain and yet is free of side reactions. One of the safest and most effective drugs which I have been using daily for eight years is Pontocaine (0.15 per cent). This drug is less toxic and more efficient than procaine when used in correct doses. Xylocaine (2 per cent)[4] has shorter action than Pontocaine, but is useful also for all types of regional anesthetic procedures. Although it has a very rapid onset of action, topical as well as otherwise, I prefer the use of Pontocaine for nerve blocks.[5-7]

Almost never do I employ oily or otherwise irritating solutions, except for absolute ethyl alcohol in 1 cc. amounts for the extreme pain of cancer, advanced tuberculosis, tic douloureux and intractable angina pectoris. Alcohol, phenol and Efocaine cause anesthesia by nerve destruction rather than by block due to the anesthetic effect and sometimes may produce irritation of tissue and pain.[8]

It would seem strange if experience had not taught that many painful diseases may be cured by interrupting the passage of nervous impulses by a chemical section. It is well established that

a physiologic state may occur when the flow of impulses along the somatic or autonomic fibers is interrupted; this procedure is often termed "physiologic sectioning."

Before one prepares the skin of the patient and puts on gloves, it is informative to palpate the bony landmarks of the region. This increased awareness and thorough knowledge of the bony relations help to make nerve blocking more precise.

Various Uses of Nerve Block Therapy

It is well to remember that bilateral superior laryngeal nerve block is indicated in persistent laryngeal pain, whether it is due to tuberculosis, cancer, or some other cause. Relief for this organ results in better nutrition because swallowing becomes comfortable again by such therapy.

There are various facial pains which may be treated effectively. Tic douloureux may be relieved by blocking the trigeminal nerve or its involved branches. When facial pain has its origin in the occiput or upper cervical vertebrae, cervical somatic nerve block is indicated. Patients with atypical facial pain have been relieved sometimes by a stellate ganglion block.

Patients may complain of pain in the shoulder or shoulders.[9] Careful inquiry may show that the pain has widely different origins, such as the cervical vertebral or diaphragmatic region. A good examination is always required. Bursitis and "frozen shoulder" are usually benefited by blocking the brachial plexus or the suprascapular nerve, the sensory pathway of the shoulder joint. Recovery in the more resistant cases may be obtained by persistent nerve blocks, heat and massage and increasing encouragement for active exercises under these analgesic blocks.

Suprascapular nerve block is a simple effective therapeutic block which is not used with the frequency that it merits. It is well to remember that the suprascapular notch is as far behind the clavicle as the coracoid process is in front of it. Palpate your own coracoid process.

Myalgias and postcoronary pain may be helped by infiltrating the tender areas with Pontocaine (0.15 per cent).

In blocking nerves for shoulder pain, hiccoughs, charleyhorse, trismus, torticollis, coccygodynia, sciatica or any pain syndrome which might be indicative of chronic disease of the nervous system, every effort should be made to obtain an accurate diagnosis first, but sometimes it becomes necessary to give symptomatic relief during the investigation.

Fortunately, in spite of the fact that many pathologic disorders may produce it, sciatica in a large number of cases is not due to serious organic diseases. In many cases of sciatica it has been found most effective not only to block the sciatic nerve, the largest nerve of the body, but also to perform a caudal block, and sometimes to block the roots of the sciatic nerve as well. This combined practice produces grateful patients.

Autonomic nerve fibers make up part of the mechanism[10] of many disease entities. A thorough knowledge of these fibers is essential to control properly the pain of pulmonary embolism, Raynaud's disease, acute pancreatitis, causalgia, intractable angina pectoris and many other conditions which affect the blood vessels, viscera and sweat glands.

For phlebitis, vascular spasm from trauma, arterial embolism, post-traumatic dystrophy of fractured bones, and phantom limb pain sympathetic block is a basic need. Such a sympathetic physiologic section[11] may be carried out by performing a sympathetic ganglion block or by epidural or subarachnoid or sometimes somatic nerve block.

For the diagnosis and surgical prognosis of peripheral vascular disease sympathetic block may be used. Prognostic block may be performed in hyperhidrosis and Hirschsprung's disease.

The only hope for the conquest of malignant disease is accurate diagnosis early. Just as this is difficult often, so is control of intractable pain in its later stages. Did you know that the excruciating pain of malignant disease and some other debilitating syndromes may be relieved completely with one or more subarachnoid alcohol blocks?

Absolute ethyl alcohol[12] is particularly hypobaric, being slightly less than eight tenths as heavy as spinal fluid. By adjusting the position of the patient so that the posterior roots (the involved spinal nerves mediating pain) are uppermost, 1 cc. of alcohol is injected slowly over a period of 10 minutes.

Thus, as these sensory fibers are destroyed, their pain fibers are removed. Such success in such a porportion of patients has been experienced that this therapy should be used to a greater extent.

For the pain of cancer distributed above the clavicles I do not prefer such a subarachnoid block, but usually perform specific block of the involved nerves. If the pain caused by cancer is relieved thus before narcotic addiction has occurred, the narcotics may be abandoned; soon eating, sleeping and living are gratefully resumed.

Occasionally one hears a physician state that he cannot become enthusiastic about nerve blocks. When possible, I inquire further into the reasons for this attitude.

One physician was infiltrating procaine into the trapezius muscle for pain in the shoulder without desirable results. Later, a diagnosis of carcinoma of the upper lobe of the lung was made in this case.

Another physician exhorted a young basketball player who had injured her ankle "to get up and walk on it." Two months later another physician brought grateful relief of the sympathetic dystrophy by a series of blocks of the lumbar sympathetic ganglia.

An old woman with Colles' fracture still had pain and disability six months later. Physiotherapy, gold injections, vitamin injections and psychiatric help all failed to relieve her misery. Several stellate ganglion blocks and reassurance brought her freedom from pain and disability.

Psychic Aspects

Every patient[13] with a pain problem should have a careful history taken and be subjected to a thorough examination. He must be handled with kindness and sympathy. Thus his personality may be investigated and his confidence gained. The patient must be convinced that his individual problem is understood and that all possible will be done to bring relief to him.

The physician must demonstrate full confidence in his methods. Unless he believes in his own therapy, his results will be poor. This fact emphasizes the great importance of the mental element. The psychiatric help directed toward the modification of the reaction to pain is often at least as important as the prevention of pain perception itself.

The conquest of pain[14] remains a most important problem, the chief aim and the most desirable achievement of every physician, at the bedside, in surgery, in the laboratory, on the battlefield and wherever man may suffer.

References

1. Brown, C. M.: Diagnostic and Therapeutic Block for Treatment of Pain, J. M. A. Georgia 39: 209-211 (May) 1950.
2. Waters, R.: Something Old, Nothing New, Southern Society of Anesthesiology Meeting (April) 1954.
3. Bonica, J. J.: Management of Pain, Philadelphia, Lea & Febiger, 1953, p. 26.
4. Hanson, I. R., and Hingson, R. A.: Use of Xylocaine, New Local Anesthetic, in Surgery, Obstetrics and Therapeutics; Preliminary Report, Anesth. & Analg. 29:136-147 (May-June) 1950.
5. Bonica, J. J.: Use of Pontocaine for Regional Anesthesia; Analysis of 3,000 Cases, Anesth. & Analg. 30:1-15 (Jan.-Feb.) 1951.
6. Bonica, J. J.: Use of Pontocaine for Regional Anesthesia; Analysis of 3,000 Cases, Anesth. & Analg. 30:76-88 (March-April) 1951.
7. Moore, D. C.: Pontocaine Solutions for Regional Analgesia Other Than Spinal and Epidural Block; Analysis of 2,500 Cases, J. A. M. A. 146:803-809 (June 30) 1951.
8. Mannheimer, W.; Pizzolato, P.; and Adriani, J.: Mode of Action and Effects on Tissue of Long-Acting Local Anesthetics, American Medical Association Meeting, June 1953.
9. Bonica, J. J.: Management of Pain, Philadelphia, Lea & Febiger, 1953, p. 710.
10. MacKenzie, J.: Some Points Bearing on the Association of Sensory Disorders and Visceral Disease, Brain 16:321, 1893.
11. Volkmann, J.: Observations on Untoward Results in Almost 78,000 Sympathetic Blocks, Beit. klin. Chir. 185(3):288-301, 1952.
12. Bonica, J. J.: Management of Pain, Philadelphia, Lea & Febiger, 1953, p. 498.
13. Bonica, J. J.: Management of Pain, Philadelphia, Lea & Febiger, 1953, p. 17.
14. Medvei, V. C.: The Mental and Physical Effects of Pain, Edinburgh, E. & S. Livingstone Ltd., 1949; Baltimore, Williams and Wilkins Company, 1949.

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Creeping Eruption Evaluation of Therapy

WILEY M. SAMS, M.D.
AND
HOLLIS F. GARRARD, M.D.
MIAMI

Creeping eruption is a recurring problem, and one which has attracted the attention of physicians in Florida for more than 30 years. The early reports by Kirby-Smith and Dove[1] and Kirby-Smith, Dove and White[2] were major contributions in this field, which helped to establish the etiology of common creeping eruption. No drug, and no method or procedure, can be evaluated in the treatment of any disease unless the natural history or course of that disorder is first considered. A review of the history, in a series of patients with creeping eruption, will at once demonstrate the wide variations which exist, in so far as severity of pruritus and duration of the eruption are concerned. Attempts have been made to explain these variations by assuming that a different species of nematode worm, or a different variety or strain of larval parasite, is responsible for the variations which are observed. It has also been suggested that the younger larval parasite will survive for a longer period in the skin.

One has only to turn to Shelmire's report[3] to learn that these variations occur when a homogenous strain of Ancylostoma braziliense is used experimentally to inoculate the skin. Here, under experimental conditions, a wide variation in the type and character of the eruption was observed from inoculations with approximately an equal number of parasites, of about the same age, in the same area on the forearm. It is noteworthy that in two experimental subjects the eruption failed to develop, even though they were exposed. One subject experienced complete spontaneous healing in seven days, without treatment. In another a single lesion developed, which disappeared in 14 days, and in a third spontaneous involution took place in nine weeks. Shelmire[3] allowed untreated linear, serpiginous lesions to progress on his arms for 52 and 92 days respectively, without treatment, except occasional freezing for relief of pruritus. These variations, observed in experimentally produced infestations, are in accord with the picture which we find in patients with accidentally acquired infections.

A survey of treatment which patients carried out for themselves indicates many indifferent remedies are apparently successful; at least cure is attributed to some method of therapy which is last in use. We are equally certain that many of our patients "cure" themselves with a wide variety of applications, and never consult a physician when the number of parasites is small and the duration of the infestation short. As physicians, we should be more critical of our therapeutic results. If a remedy is good and sufficient, it should promptly control the pruritus, and prove effective in a matter of days, rather than in a period of weeks. If the drug taken orally, administered parenterally, or applied topically, is an effective larvacide, then it should promptly stay the migration of the parasite which is under treatment and, if administered systemically, it should produce comparable results in all of the parasitic larvae which are present in the skin. When the number of viable parasites diminishes slowly over a period of weeks, we have the picture which may occur with spontaneous involution, or one which is the result of gradual mechanical removal of the parasites by scratching, or of the occurrence of inflammatory reaction and secondary infection, which may result in discharge of the parasite in the crust and exudate from the lesion.

It is not too early to reopen the discussion on the treatment of creeping eruption, for the practitioner in Florida is confronted with this troublesome problem with the advent of the rainy season during the summer months. In an article[4] published in The Journal last October, Hetrazan was again presented as a therapeutic agent of

value. The results reported would lead one to believe that it is a highly effective agent. Unfortunately, neither we, nor certain other physicians in the state, have been able to obtain such good results as those reported in the use of Hetrazan,[5] even though the dose of the drug was raised to the level recommended, and administered, in some cases, according to the reported schedule. At the time this paper was published, we held a letter, written under date of Sept. 13, 1953, from Dr. Van De Erve,[6] in which he stated: "Hetrazan has been completely disappointing since the first year's flush of enthusiasm." It is, of course, disappointing to have our therapeutic efforts nullified by subsequent experience, but as physicians we must continue to search for effective, expedient and safe methods of treatment, which will not incapacitate the patient, nor expose him to any risk or hazard, for we are treating a self-limited process which, though exasperating, is followed by no complications which are a hazard, in so far as life or subsequent health is concerned. Loewenthal,[7] of Johannesburg, South Africa, reported successful treatment in 7 out of 8 cases of sandworm disease (creeping eruption) with Hetrazan. He used only 2 mg. per kilogram, and the duration of treatment varied from 13 to 28 days. His single failure occurred in a patient with multiple lesions.

Report of Cases

Case 1. — R. B. F., a white boy, aged 7, had 25 to 30 lesions of three weeks' duration, on the feet, legs and buttocks. He was given Hetrazan, 75 mg. three times a day. The weight was 26 Kg. After five days the pruritus had not lessened; so his mother stopped the drug and reported that she treated the lesions with acetic acid, over a period of three months before all of the larvae were inactive.

Case 2. — W. B., a white boy, aged 2, had 30 to 40 lesions of two weeks' duration on the back, abdomen and buttocks. He was given Hetrazan, 50 mg. four times a day for 10 days, without any subjective or objective improvement. No toxic symptoms were noted. He received a total of 2 Gm. of the drug. The lesions were then treated with dry ice on eight occasions, over a five week period, before all lesions were quiescent.

Case 3. — J. C. H., a white boy, aged 9, had 150 to 200 burrows on the hands, buttocks and legs, of five days' duration. He was given 75 mg. of Hetrazan three times a day. Two days later the dose was increased to 100 mg. three times a day and continued for 15 days. At the end of this period he still had many active larvae, which the mother treated with ethyl chloride for three more weeks. The pruritus and migration of the larvae were not controlled by the Hetrazan. A total of 4.7 Gm. was taken.

Case 4. — T. O., a 29 year old plumber, had more than 50 lesions on his legs, thighs and buttocks, of three days' duration, and was given Hetrazan, 400 mg. three times a day, which he took for five days, but stopped on account of severe nausea and vertigo. The pruritus remained the same, and the migration of the parasites continued. A total of 6 Gm. was taken. He was then treated with dry ice six times over a three week period, with apparent success.

Case 5. — W. H., a white man, aged 42, weighing 70 Kg., with from 30 to 40 burrows on his legs and thighs, of one week's duration, was given 300 mg. of Hetrazan three times a day for seven days, without any lessening of the pruritus, and no objective improvement. Freezing with dry ice was then started and continued for three weeks, after which time there were no active lesions.

Case 6. — J. L., a white man, aged 27, with 50 to 60 lesions on the buttocks and thighs, of a few days' duration, took 1,000 mg. of Hetrazan daily for eight days, and nausea, vomiting and vertigo developed. The itching and migration of the parasites were not controlled. He was then treated eight times with dry ice, with good results.

Case 7. — W. E. P., a white man, aged 52, had had about 50 lesions on his legs for one week when first seen on Sept. 12, 1953. He was treated with ethyl chloride freezing and dry ice several times. On October 12 Hetrazan, 200 mg. three times a day, was started. Two days later the dose was increased to 600 mg. three times a day and was continued to October 26, during which time 392 50 mg. tablets were taken. The average daily dose was 1,470 mg., and the total dose was 20.6 Gm. He thought that the itching was fairly well controlled, but he had to stop the drug as severe headache, vertigo, nausea and a temperature of 102 F. developed. The larvae continued to crawl, and he was treated by various local methods, with rather indifferent results. He still had two active lesions on March 11, 1954, more than six months after treatment was instituted. Now, eight months after the onset of the infestation, he is apparently clear of active lesions.

Case 8. — C. R., a white man, aged 55, who had 40 to 50 burrows on his arms, abdomen and back, was given Hetrazan, 800 mg. three times a day about seven days after the onset of the disease. He vomited after the third dose. He was able to tolerate 350 mg. three times a day, however, which was continued for nine days. Since there was no improvement, the drug was stopped after 10 Gm. was taken. He consulted another physician, who prescribed Hetrazan syrup, three teaspoons, 450 mg. every six hours. This caused nausea; so the dose was reduced to three teaspoons three times a day, which he tolerated and continued until 24 ounces of the syrup was taken, making a total of 28 Gm., and a grand total of 38 Gm., including the first course of Hetrazan. Despite the total dose, the parasites were still migrating. Freezing with ethyl chloride, and the use of other topical remedies, afforded relief from pruritus, and all of the lesions were quiescent after a four months' period.

In addition to the cases reported, we have had a number of oral communications from physicians using Hetrazan according to previous recommendations, who have reported that they have been unsuccessful with the drug. We have several letters from physicians in the state, one[8] of whom reported: "Two patients were treated with Hetrazan for larva migrans, in the doses recommended by . . . .[4] One said itching was much relieved; one said there was no effect on the itching. In neither case was migration of the larvae diminished, and neither case was cured." A second physician[9] reported: "I have given the drug in larger and smaller doses than those recommended in the article. . .,[1] without obtaining the results reported. I have tried many drugs for larva

migrans, and I feel that there are others which give as good, or better, results than Hetrazan."

Our personal experiences with systemic therapy in creeping eruption have not been extensive, because we have limited its use to those cases with massive infestations. Where a single, or a few lesions are present, we believe that the judicious use of topical applications can be effective, and no more disagreeable than the nausea and vomiting which some of the patients report from high doses of the drug administered. To be more specific, 70 cases which we have accumulated between us during the past year were reviewed. Twenty-seven of the 70 patients had but a single lesion. The average duration of the infestation was 20 days, and the average time for cure, with topical treatment, was eight days. When two lesions were present, the average time required for cure was 12 days; with three lesions, 22 days; with three to four lesions, 19 days; and with five to 20 lesions, 22 days. With 20 and more lesions, 66 days on the average was required for involution, and this group included 8 of the 12 cases with heavy infestations, in which Hetrazan was employed in treatment. It is of interest to observe that 23 of our patients were cured by a single treatment, in which we used either ethyl chloride or dry ice. We believe that the topical methods of treatment are successful, not because the parasite is killed by the freezing, or by local applications, but because these measures bring about inflammatory reaction, which effects a mechanical removal of the parasite.

Additional doubt is cast on the probable value of various methods proposed for systemic therapy when one reads the paper published by Ritchie and King,[10] in which in vitro studies on the larvacidal action of various drugs were reported. It was found that the aqueous solution of oxophenarsine (Mapharsen 0.6 per cent), Hetrazan 2.5 per cent and stibophen (Fuadin 6.3 per cent) failed to render the larvae of A. braziliense inactive after being exposed to the drug for a period of 24 hours. A somewhat better report was offered for Stibanose, which inactivated the larvae in three hours, in a 2 per cent aqueous solution. Returning to Hetrazan, it might be observed that it would require 1.5 Kg. of the drug for a patient weighing 60 Kg., to be given in a single dose and completely absorbed, to produce the same concentration in the body, if we can assume that it is equally absorbed by each of the various tissues. This parasite migrates in the prickle cell layer of the epidermis, and it is reasonable to assume that it is not exposed to concentrations as high as those which are obtained in the treatment of nematode infestations of the gastrointestinal tract.

Conclusion

The efficacy of both local and systemic measures for the treatment of creeping eruption must be evaluated with a knowledge of the natural history of the disorder, and the variations which occur when no treatment, or indifferent treatment, is extended. We are forced to repeat again the concluding sentence in the article[11] published in Current Therapy: "All suggested systemic remedies have, in our experience, proved unsuccessful."

References

1. Kirby-Smith, J. L., and Dove, W. E.: Creeping Eruption in Southern States with Entomological Report, South. M. J. 18:402-411 (June) 1925.
2. Kirby-Smith, J. L.; Dove, W. E., and White, G. F.: Creeping Eruption, Arch. Dermat. & Syph. 13:137-175 (Feb.) 1926.
3. Shelmire, B.: Experimental Creeping Eruption from Cat and Dog Hookworm (A. Braziliense), J. A. M. A. 91:938-944 (Sept. 29) 1928.
4. Kelley, E. P.: Treatment of Creeping Eruption, J. Florida M. A. 40:242-245 (Oct.) 1953.
5. Van De Erve, J. Jr.: Creeping Eruption, Systemic Therapy, J. Invest. Derm. 12:69-79 (Jan.) 1949.
6. Van De Erve, J. Jr.: Personal communication, Sept. 13, 1953.
7. Loewenthal, L. J. A.: Treatment of Sandworm Disease with Hetrazan, South African M. J. 24:999-1000 (Dec. 2) 1950.
8. Waisman, M.: Personal communication, Nov. 5, 1953.
9. Wilson, W.: Personal communication, Oct. 30, 1953.
10. Ritchie, E. B., and King, W. C.: Observations on Reactions of Larvae of Ancylostoma Canium and Ancylostoma Braziliense to Various Drugs and Chemical Compounds Based on In Vitro Tests, J. Invest. Derm. 20:337-341 (May) 1953.
11. Creeping Eruption, Method of Wiley M. Sams, M.D., in Current Therapy 1952, edited by H. F. Conn, Philadelphia, W. B. Saunders Company, 1952, p. 520.

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1954 MEDICAL DISTRICT MEETINGS

"A" Marianna	October 11
"B" Sanford	October 13
"C" Sarasota	October 15
"D" Vero Beach	October 14

Bronchial Adenoma and Lung Cancer

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Differences of opinion still exist regarding the nature of bronchial adenoma and its relation to cancer of the lung. Evidence, however, is mounting which indicates that although most tumors of this type are only locally malignant, a certain small percentage undergo frank malignant degeneration and metastasize widely.

Data will be presented on 42 consecutive patients in whom the diagnosis of bronchial adenoma was established by microscopic examination of tissue. All were treated by resection. In 1 patient there was recurrence following resection, and this recurrence took the form of distant metastases, resulting in death.

During the identical period in which these 42 cases were observed, 980 patients were seen in whom the diagnosis of primary cancer of the lung was made. Those with adenoma comprised 4.3 per cent of the total group (table 1).

Table 1. — Adenoma of the Bronchus: 1932-1951

	Cases
Total	42
Carcinoma same period	980
Adenoma	4.3%

In this series there were 24 females and 18 males (table 2). In a series of 233 cases which were collected from the literature in which the sex incidence was noted, there were 133 females, or 57 per cent.[1-4] It would appear that the disease is almost as common in males as in females.

Table 2. — Adenoma of the Bronchus: Sex Incidence and Age at Onset of Symptoms*

Age	Cases
9-20	7
21-30	8
31-40	10
41-50	10
51-60	2
Over 60	3

Males 18; Females 24. Youngest 9; Oldest 71.

*In 2 cases adenoma was an incidental finding at operation for bronchogenic cyst in 1 case and for bronchiectasis in 1 case.

Read before the Florida Chapter, American College of Chest Physicians, Fifth Annual Meeting, Hollywood, April 26, 1953.

Thirty-five of the 42 patients were less than 50 years of age at the onset of symptoms, and 15 were less than 30 (table 2). The average duration of symptoms was longer than in patients with carcinoma (table 3). Nearly half had symptoms more than three years.

Table 3. — Adenoma of the Bronchus: Duration of Symptoms

Years	Cases
Less than 1	17
1-2	5
3-5	9
6-10	4
11-20	5
Over 20	2

The symptoms most frequently complained of are listed in table 4. Three patients were asymptomatic.

Table 4. — Adenoma of the Bronchus: Symptoms

	Cases
Total	42
Cough	36
Hemoptysis	21
Massive hemorrhage	5
Fever	16
Wheezing	6

Roentgenographic evidence of disease of the lung was present in 38 of the 42 cases, or 90 per cent. The roentgenograms were all conventional films of the chest. Bronchograms are of relatively little value, since central tumors can be visualized bronchoscopically, while peripheral tumors or the distal effects of bronchial occlusion usually show up in conventional roentgenograms. The majority of bronchial adenomas arise from the main bronchi or their primary subdivisions, and are visible bronchoscopically (tables 5 and 6). Six tumors arose from peripheral bronchi. In a few cases specimens for biopsy were not taken because of obvious vascularity of the tumor and the fear of subsequent hemorrhage.

Table 5. — Adenoma of the Bronchus: Bronchoscopy

	Cases
Total	42
Bronchoscopy performed	37
Tumor visible	28
Biopsy taken	22
Biopsy positive	20

Table 6. — Adenoma of the Bronchus: Location in 42 Cases

Central	36	
Peripheral	6	
Right side:		
Main bronchus		1
Upper lobe bronchus		2
Middle lobe bronchus		5
Lower lobe bronchus		12
Posterior segment upper lobe		1
Basilar segment lower lobe		1
Superior division lower lobe		1
Left side:		
Main bronchus		5
Upper lobe bronchus		7
Lower lobe bronchus		4
Apical posterior segment upper lobe		2
Basilar segment lower lobe		1

In all cases of this series treatment was by excision (table 7). Forty-one patients were treated by lobectomy or pneumonectomy, and 1 by transpleural bronchotomy and local excision. This latter patient has been closely followed for almost four years without evidence of recurrence.

Table 8. — Adenoma of the Bronchus: Survival

	Cases
Total	42
Operative deaths	2
Late deaths	1
Living and well	39

One patient in whom resection was carried out died later of metastases.

Report of Case

H. S., aged 51, was admitted to the Deaconess Hospital on June 28, 1943. In 1937 he began to have cough, attacks of fever, expectoration, and hemoptysis. In 1940 bronchoscopy was carried out elsewhere. A benign tumor was found in the orifice of the upper lobe of the left lung. Repeated bronchoscopies with partial removal of the tumor were performed. The patient, however, continued to have a persistent cough and bouts of pneumonitis, and was referred for surgical treatment.

Physical examination revealed a well developed and nourished white man. There were coarse rales, heard best anteriorly over the upper field of the left lung. The remainder of the examination gave negative results. Total pneumonectomy was performed on Sept. 14, 1943. The pathologic report was "infiltrating bronchial adenoma." There was no involvement of the lymph nodes.

He made a good recovery and remained well until late 1944, when he began to go downhill. On July 29, 1945, he died, and autopsy showed diffuse metastases to the liver, spleen, right lung, mesentery, and tail of the pancreas. The histologic picture was similar to that of the original lesion.

The tendency of bronchial adenoma to invade and infiltrate contiguous tissue is well known. In the cases under discussion, 20, or 47 per cent, of the lesions showed local invasion of contiguous structures, and 6 showed invasion of lymph nodes. The 1 case described illustrates the ability of this tumor to metastasize widely.

Table 7. — Adenoma of the Bronchus: Extent of Resection in 42 Cases

Right side:		Left side:	
Pneumonectomy	12	Pneumonectomy	13
Upper lobectomy	1	Upper lobectomy	2
Middle and lower lobectomy	9	Lower lobectomy	2
Lower lobectomy	2	Bronchotomy and local excision	1

The results of surgical treatment are shown in table 8. Thirty-nine of the 42 patients are living and well after resection. One patient died suddenly 12 hours after uneventful pneumonectomy. He reported to the nurse that he was feeling fine only a few minutes before he suddenly became dyspneic and cyanotic. Death rapidly ensued. Autopsy was refused, but he was thought to have had an acute coronary occlusion. The other patient died on the second postoperative day. The final diagnosis at autopsy was bronchopneumonia.

In a review of the literature I was able to find 9 cases in which distant metastasis from a bronchial adenoma had occurred. Adams, Steiner and Bloch[5] reported 2 such cases. In 1 there were metastases to the mediastinal lymph nodes and to the liver. In the other there was metastasis to the vertebral bone marrow. Graham and Womack[6] reported 2 cases in which metastasis to the liver occurred. Anderson[7] reported 2 cases with metastases to the liver. Moersch and McDonald[4] reported 2 cases with metastases to the liver, and

another in which there was a metastasis to the lingula from a primary tumor in the lower lobe of the left lung. Goldman[8] reported a case in which the lesion, first diagnosed bronchial adenoma, underwent malignant transformation with death resulting from widespread metastases. Burrell[9] reported a case in which a fibroadenoma was removed through the bronchoscope. Several years later a carcinoma of the bronchus developed, and the patient died. Kirch,[10] Malkwitz,[11] and Von Pein[12] had previously reported cases in which malignant transformation of a benign bronchial adenoma had occurred. Other less well documented cases have been cited, but have been purposely omitted from this discussion. It would appear then that in a certain small percentage of cases, 1 of 42, or 2.4 per cent, in this series and 3 of 74, or 4 per cent, in the series reported by Moersch and McDonald,[4] distant visceral metastases occurred from a primary bronchial adenoma.

Summary

A series of 42 cases of adenoma of the bronchus is presented, and the clinical features are discussed.

In all cases treatment consisted of resection, and all patients have been followed to date. There were 2 operative deaths and 1 late death; the latter is discussed in detail.

The potentially malignant character of bronchial adenoma is illustrated by the 1 late death. In this case the original diagnosis of the resected tumor was bronchial adenoma; yet the patient later died of widespread metastases.*

*The data presented are from the Overholt Thoracic Clinic and the Deaconess Hospital, Boston.

References

1. Brunn, H., and Goldman, A.: Differentiation of Benign from Malignant Polypoid Bronchial Tumors, Surg., Gynec. & Obst. 71:703-722 (Dec.) 1940.
2. Clerf, L. H., and Bucher, C. J.: Adenoma (Mixed Tumor) of Bronchus; Study of 35 Cases, Ann. Otol., Rhin. & Laryng. 51:836-850 (Sept.) 1942.
3. Mason, D. G., and Coberth, T.: Adenoma of Bronchus with Successful Pneumonectomy; Report of Case, Arch. Surg. 45:542-550 (Oct.) 1942.
4. Moersch, H. J., and McDonald, J. R.: Bronchial Adenoma, J. A. M. A. 142:299-304 (Feb. 4) 1950.
5. Adams, W. E.; Steiner, P. E., and Bloch, R. G.: Malignant Adenoma of Lung; Carcinoma-like Tumors with Long Clinical Course, Surgery 11:503-526 (April) 1942.
6. Graham, E. A., and Womack, N. A.: Problem of So-Called Bronchial Adenoma, J. Thoracic Surg. 14:106-119 (April) 1945.
7. Anderson, W. M.: Bronchial Adenoma with Metastasis to Liver, J. Thoracic Surg. 12:351-360 (April) 1943.
8. Goldman, A.: Malignant Nature of Bronchial Adenoma, J. Thoracic Surg. 18:137-148 (April) 1949.
9. Burrell, L. S. T.: Discussion on the Value of Bronchoscopy in Diagnosis and Treatment, Joint Discussion No. 2, Section of Laryngology and Section of Medicine, Proc. Royal Soc. Med. 31:421 (Dec. 3, 1937) 1938.
10. Kirch, E.: Ueber stenosierende Bronchialgeschwülste mit konsekutiver Bronchiektasenbildung, Centralbl. f. allg. Path. u. path. Ant. 28:545-569, 1917.
11. Malkwitz, F.: Beitrag zur Kenntnis polypöser Bronchialkarzinome, Frankfurt Ztschr. f. Path. 26:189-199, 1921.
12. Von Pein, H.: Ueber ein stenosierendes polypöses Bronchialkarzinom München, med. Wchnschr. 76:1888-1889 (Nov. 8) 1929.

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REPORT ON A. M. A. MEETING

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Perforation of the Cecum by Ascaris

John P. Gifford, M.D.
VERO BEACH

Of the several hundred metazoan, or multicellular, parasites known to infest man, among the few that are important are certain of the roundworms. Chief among the several species which inhabit the intestine of man is Ascaris, the largest of the roundworms. These lumbricoid parasites may infest the cecum and appendix of children, causing no symptoms if there is mild infestation, with few worms. On the other hand, the infestation may be severe with wide involvement, as in the unusual case presented.

Report of Case

J. S., a 2 year old Negro boy, was brought to my office in January 1954 with a history of passing roundworms the previous day. The patient's weight was 14 Kg. Treatment was instituted with syrup of diethylcarbamazine (Hetrazan), 1 dram three times a day. The child was seen on the following day, apparently improved, having passed a number of worms, and also on the third day, when his condition was satisfactory as he had passed several more worms. On the fourth day, he was brought to my office in a moribund condition, with a temperature of 103 F. rectally, grunting respirations, and a tense, distended, silent abdomen. A tentative diagnosis was made of intestinal perforation with peritonitis, due to perforation of the bowel by roundworms, and the patient was admitted to the Indian River Memorial Hospital.

That day, the fourth day of treatment, examination of the blood showed red blood cells 3,908,000, white blood cells 18,750, hemoglobin 11.7 Gm., color index 1.0, polymorphonuclears 86, lymphocytes 14, segmented forms 70, stab forms 15, and juvenile forms 1. Urinalysis revealed specific gravity 1.037, a trace of albumin, and 12 white blood cells per high power field.

At operation, the abdomen was explored through a right paramedian incision. There was a perforation of the cecum about 1.5 cm. from the base of the appendix. This was repaired. Nine adult ascarides were removed from the peritoneal space, one from near the pyloris, five or six from between the leaves of the small bowel, and one or two from the pericolic gutter. Of these, seven were dead and two were alive. The appendix was then amputated, as it was distended and injected, and two worms were severed in the amputation of the appendix. Four hundred thousand units of penicillin and 0.5 Gm. of streptomycin were placed in the peritoneal space, and the abdomen was closed in layers.

Postoperative treatment was instituted with large doses of penicillin and streptomycin and duodenal suction. The course was septic; the temperature was 103 F. for the next several days. On the fifth day, the child began to take fluids well, suction was discontinued, peristalsis was active, and the bowels began to move spontaneously. From the sixth to the ninth day, the temperature ranged between 101 and 105 F.; however, during this period the child took liquids well, and the bowels moved daily although the abdomen remained distended. On the tenth day, the sutures were removed, and a snug binder was applied.

That afternoon dehiscence of the incision occurred. The patient was again subjected to surgery, and the abdomen was closed in layers. At this time, there was no evidence of gross peritonitis. For the next five days, the course was highly septic. During this period Terramycin was administered intramuscularly. By the seventeenth day, the temperature was approximately normal, the child appeared much more alert and became interested in food, and the bowels were moving daily. He was eating well, and the temperature was entirely normal by the twenty-first postoperative day. Abdominal distention, however, was at times still a problem, requiring enemas even though the bowels had moved that day. The twenty-third day after admission a course of Crystoids was instituted followed by the passage of several dead worms. On the twenty-sixth day, the patient was discharged from the hospital to continue treatment as an outpatient.

This case is reported as one of general interest. Over the past 10 years I have used Crystoids for the treatment of roundworms. This is the first case in which I have used Hetrazan. It is also the first case I have observed in which perforation occurred.

1625 Osceola Boulevard

A. M. A. CLINICAL SESSION

MIAMI, NOVEMBER 29-DECEMBER 2, 1954

ABSTRACTS OF MEDICAL ARTICLES

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 1018, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

The Journal of the American Medical Association is limiting its Current Medical Literature section. Thus, our main source of information on articles written by our members has been greatly curtailed.

Important Details Concerning the Argyll Robertson Pupil. By Curtis D. Benton Jr., M.D. Am. J. Syph., Gonor. & Ven. Dis. 37:232-236 (May) 1953.

When Douglas Argyll Robertson, in 1869, described what he called spinal miosis, he named five criteria characterizing the condition which, when present, were in his opinion indicative of syphilis of the central nervous system and nothing else. Three other features have since been observed. These eight features are: 1. The retina is sensitive to light. 2. The pupil does not contract on exposure to light. 3. There is contraction during the act of accommodation for near objects. 4. The pupil constricts with eserine, but dilates poorly with atropine. 5. The pupil must be small. 6. Irregularity of the pupillary outline. 7. Loss of the sensory reflex (dilatation of the pupil on pinching the skin of the neck). 8. Atrophic changes in the iris.

Dr. Benton describes these features and discusses the significance of the Argyll Robertson pupil in the diagnosis of syphilis. He also discusses the site of the causative lesion.

A Pyrogen-like Complication of Cardiac Catheterization: Its Pathogenesis. By F. A. Hernandez, M.D., and Milton S. Saslaw, M.D. Am. J. M. Sc. 225:626-629 (June) 1953.

In the course of cardiac catheterizations performed at the National Children's Cardiac Hospital in Miami late in 1951 and early in 1952, the authors observed a pyrogen-like syndrome, characterized by chills, fever, prostration, headache and backache in 9 of 11 patients with mitral stenosis. They found that these reactions were eliminated by subjecting the catheters to thorough washing with saline. They note that heat also has been found effective.

It was their conclusion that these reactions are similar to pyrogen-like reactions reported by Dameshek and Neber following transfusions of compatible whole blood. In their opinion, a factor similar to, or identical with, the heat-labile "PTR" factor described by these investigators and by Crosby and Stefanini may be responsible for the cardiac catheterization complication. They offer two possible explanations for the occurrence of this complication only in mitral stenosis and not in congenital heart disease. First, the pathologic changes in the pulmonary epithelium of patients suffering from rheumatic mitral stenosis may render this tissue more susceptible to the "PTR" factor. Second, there may be certain conditions in which there is a predilection to plasma transfusion reactions.

Thoracic Renal Ectopia. By H. Stephen Weens, M.D., and M. Harlan Johnston, M.D. Am. J. Roentgenol. 70:793-796 (Nov.) 1953.

A case of congenital thoracic renal ectopia is reported, and the importance of this anomaly in differential diagnosis of thoracic masses is stressed. The frequency and the embryology of the condition are discussed briefly. The roentgenologic aspects are also discussed, and emphasis is placed on proper roentgenographic technic in the detection of high renal ectopia.

Pituitary Necrosis Following Osteomyelitis of the Sphenoid Bone. By N. F. Coulter, M.D., and D. A. J. Morey, M.D. South. M. J. 46:907-909 (Sept.) 1953.

The profound influence of the pituitary gland upon the life processes is emphasized by a case reported here in which there developed an acute, purulent, inflammatory necrosis of the pituitary gland, secondary to an osteomyelitis of the sphenoid and bony erosion with fistula formation between the superior nasopharynx and the sella turcica.

Possible etiologic factors are considered. The autopsy findings raised the question of whether or not trauma to the head and face four months prior to this illness, the snuff habit, or an unestablished chronic sinusitis was the initial process which led to the bony erosion and necrosis of the pituitary gland.

Local Anesthesia in the Male Urethra. By Joseph C. Hayward, Louis M. Orr and Henry F. LaGuette. J. Urol. 70:624-625 (Oct.) 1953.

This brief article presents a method of local anesthesia in the male urethra during cystoscopic examination, which has proved most satisfactory over a period of years. It is concluded that the use of 4 per cent metycaine solution in the anterior urethra, followed by instillation of metycaine tablets in the posterior urethra, as described, is a safe effective means of securing anesthesia for this purpose.

Melorheostosis Leri; Report of a Case and a Brief Review of Literature. By Richard D. Shapiro, M.D., William H. Bernstein, M.D., and T. M. Berman, M.D. South. M. J. 46:1102-1104 (Nov.) 1953.

Melorheostosis Léri is an osseous abnormality which consists of thickening of the bone or hyperostosis increasing from the proximal to the distal aspect of the bone and distributed along the side of the bones of an extremity. Since it was first described in 1922 by Léri and Joanny, reports of some 50 isolated cases have accumulated. The literature is here reviewed in an attempt to define the nature of this rare and rather specific clinical entity. A case is described in which there was a typical roentgenologic pattern and a history of slow progression over a 16 year period.

Oral Procaine in Heartburn and Other Functional Upper Gastrointestinal Symptoms. By Benjamin G. Oren, M.D. South. M. J. 46:946-953 (Oct.) 1953.

In this study 38 consecutive office patients with heartburn and other functional complaints associated with increased muscle tone in the upper part of the gastrointestinal tract were treated with procaine in an attempt to relieve their symptoms. Eighteen patients experienced complete relief symptomatically of both heartburn and epigastric fulness. Six obtained partial relief, and 14 experienced no relief or aggravation of symptoms.

Procaine in 80 mg. dosage has a stimulating effect upon acid secretion in the stomach, similar to that of 50 cc. of 7 per cent alcohol. Several patients with peptic ulcer became worse under procaine therapy. It is concluded that while procaine may temporarily relieve smooth muscle spasm in the upper portion of the gastrointestinal tract by direct contact with the mucosa, its use appears to be contraindicated in peptic ulcer disease.

Findings in Patients Suffering from Anxiety States Treated with a Muscle Relaxant. By Lowell S. Selling, M.D., Ph.D., Dr.P.H., F.A.C.P. South. M. J. 46:1204-1210 (Dec.) 1953.

This report indicates that the substance known commercially as Prenderol offers some promise in healing or in helping recovery in anxiety and other tension states. The toxicity of the drug is low, it can be prescribed over a long period of time with safety, and it is not habit-forming. Its drawbacks are the size of the dose, its unpleasant taste, some gastric discomfort and a tendency to cause drowsiness, sometimes to a dangerous degree.

From an analysis of 116 cases in which Prenderol therapy was employed for varying periods of time, it was concluded that Prenderol produces a pronounced feeling of relaxation in the tension states (anxiety neurosis). Recovery is aided by psychotherapy given simultaneously, but occasionally spontaneous recovery apparently occurs. Patients subjected to controlled Prenderol therapy find that they sleep better. Trials on nonpsychiatric patients, including the author, indicate that even a large dose may not produce detectable subjective feelings when no tension

complaints are present; but when a healthy person is "keyed up," he may experience a pleasant feeling of relaxation after a small dose. The drug appears to be a useful adjuvant for psychotherapy, particularly for hypnosis. Combined with amphetamine, it promises to relieve nonpsychotic depressions. Some patients report relief of premenstrual tension.

Apparently, Prenderol does not alter a depressed mood, nor can it aid in reducing fears, particularly those annoyingly present during shock treatment. Its value during shock treatment, however, has yet to be evaluated. This drug does not seem to be beneficial in cases of psychosis. Patients should be well selected so that if psychotherapy is indicated, they will not experience a let-down and a sense of failure which may come from depending on Prenderol alone. The drug still seems to be best used in psychiatric hands.

The Public Health Laboratory, Yesterday, Today and Tomorrow. By Albert V. Hardy, M.D., Dr. P. H. Pub. Health Rep. 68:968-974 (Oct.) 1953.

In this review of public health laboratory services, Dr. Hardy presents Florida's experience of half a century as, in general, illustrative of the history, present activities, and outlook of the various state public health laboratories. Initially, attention was concentrated on the acute communicable diseases. Tests at first were employed largely for confirmation of diagnosis; later they were used in increasing numbers for case finding and the detection of carriers. More exacting tests by more expert personnel became essential for the accurate identification of residual infections.

The present period of development places major emphasis on the chronic infections. The need for simple procedures for case finding and for more highly sensitive and specific tests for diagnosis has become evident.

For the future, there are numerous unexplored problems in viral and other infectious diseases. Ahead, there is a call for continuing and increasing work in sanitary bacteriology, a broad development in public health chemistry, closer integration of all laboratory services provided at public expense, new and expanding work in chronic diseases, and an educational program designed to aid in improving the quality of medical laboratory service wherever it is performed. Special studies and active research programs will be required to encourage the development of laboratory personnel and to elevate the stature of the public health laboratory.

Future objectives include obtaining adequate facilities and acquiring, training, and retaining highly competent professional laboratory workers, with guidance for each worker in attaining a highly satisfying and productive professional experience. The opportunities and needs of the future equal or exceed those of the past.

Acute Diverticulitis of the Cecum, A Report of Six Cases. By C. C. Collins, M.D. Am. Surgeon 19:1137-1143 (Dec.) 1953.

A series of 6 cases of diverticulitis of the cecum, representing those encountered at the Cincinnati General Hospital in the past 10 years, is reported. The anatomic differences between these cases of true or congenital diverticula and the false or acquired type, mainly occurring in the sigmoid colon, are presented. Attention is directed to the close similarity between this disease and appendicitis and to their usual indistinguishable symptoms and physical findings.

In this series the average age was 52.8 years, considerably higher than the average age of 40.6 years in a larger collected series. The equality of sex incidence conformed to the usual pattern, but the incidence of nausea in 5 cases and vomiting in 4 was unusually high. Preoperatively, in 4 cases the diagnosis was acute appendicitis; in 1, carcinoma of the cecum; and in 1, acute cholecystitis. At operation, the correct diagnosis of diverticulitis of the cecum was made in 4 cases. In the fifth case the diagnosis was carcinoid of the cecum and in the sixth carcinoma of the cecum and ascending colon, with intestinal resection following in both.

Correct diagnosis of acute diverticulitis of the cecum is nearly always established by the information obtained at operation. Nevertheless, an incorrect diagnosis is made in almost one third of the cases, which leads to unnecessary resection of the colon and to a mortality rate of 10.3 per cent, as compared with 2.2 per cent for those correctly diagnosed. Measures to be utilized in diagnosis at the operating table are discussed.

A plan for surgical management is suggested which should minimize the risk of operative complications.

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Antibiotics Misused

New drugs are too often heralded as miracle-producing, wonder-working remedies. On their advent they are received enthusiastically and frequently regarded as a panacea or at least a specific cure for this or that. After passing through various stages, they eventually settle down into their proper sphere of usefulness or are in some instances discarded. The antibiotics are no exception. There is comment from many sources nowadays on the misuse of these drugs as, with the passage of time, they seek their level in the physician's armamentarium against disease.

This opinion is reflected particularly in medical press comments on last fall's Washington Symposium on Antibiotics. The British Medical Journal,[1] for example, observed that there seemed to be universal agreement at that meeting that antibiotics were being grossly misused. One Symposium speaker described the American populace as "an enormous sponge with an infinite capacity for absorbing antibiotics." Another disapproved of the common practice of administering drugs successively or together for no more precise indication than fever, and blamed advertising pressure in part for this popular method of treatment. Still another described the medical profession as "inundated literally with a plethora of drugs." In his plea for a return, for many purposes, to an earlier, simpler, cheaper, and often no less effective treatment, he advised his audience not to "write off an obituary of sulfa drugs in the current high-power antibiotic era."

A great deal of such need as there is for new antibiotics, commented the British observer, arises from the waning power of their predecessors, which results from the acquired resistance of bacteria to them. The adaptability of microorganisms to changes in environment unfavorable to their growth or even to their existence has long been well established. "Yet," in the editorial opinion of the New York State Journal of Medicine, "the longevity of man also continues to increase even granting a certain amount of misuse of drugs, antibiotics, or what have you. It would seem reasonable to assume that mankind is acquiring a certain durability by virtue of which he may be able eventually to survive even the cures for his ailments."[2] Certainly these are times when man needs all the durability

he can muster, not alone to survive the cures for his own ailments but to make survival worth while by devising the drastic cures needed for the ailments which beset the world in which he must live.

1. Washington Symposium on Antibiotics, Brit. M. J. 2:1043 (Nov. 7) 1953.
2. Misuse of Antibiotics, New York State J. Med. 54:1148-1149 (April 15) 1954.

Check-Up on Heartbreak Stories

In the January Journal attention was directed editorially to exploitation of heartbreak cases by television, radio and newspapers. The heartbreak case was defined as one in which an appeal is made for funds through television, radio and press to pay for extensive medical care or an operation, the cost of which is overwhelming to the person involved, and it was pointed out that in many instances patients preferred to glamorize their plight rather than seek available medical care.

It is only natural that the thousands upon thousands of physicians who give freely of their services to innumerable potential heartbreak cases day in and day out in the course of their everyday duties should resent the damaging effect of this dramatization on the good name of American medicine. Many members of the medical profession, for example, have long questioned the heartbreak stories of some participants appearing on the nationwide "Strike It Rich" television show, which many times has left the millions of its viewing audience with the impression that financial assistance was needed in paying for the high cost of medical care.

In recent weeks, Walter Framer, producer of the show, was interviewed by Public Relations Director Leo Brown of the American Medical Association and Robert Potter, executive secretary of the Medical Society of the County of New York. Mr. Framer disavowed any intention of discrediting the profession, for which he apparently had great admiration, and later requested the American Medical Association to check two cases.

In one of these cases, an appeal was made on behalf of the prospective participant on the basis that because of repeated illness a total medical bill of approximately $6,000 had accumulated. Investigation disclosed that the family was covered by Blue Cross and had used this service frequently. The physician had had a frank discussion of fees with the parents, who had expressed complete willingness to assume the responsibility of paying for the medical care involved. Social service workers and various hospitals provided additional information which established that at no time had the patient been without medical care for financial reasons.

The second case was that of a 16 year old boy, blind since birth, who wished to appear on the program to obtain sufficient funds to pay for comprehensive examination of his infirmity. It transpired that he had had repeated examinations by the chief of ophthalmology at one of the medical colleges and for a number of years had been attending a state school for the blind.

Investigation in both instances revealed that the persons seeking to participate on the program had been adequately taken care of at the community and state level, and that, consequently, there was little basis for the appeal. When the information was made available to Mr. Framer, they were considered ineligible. It would seem that further initiative on the part of the medical profession might prove salutary in this matter. In addition, some alert producer could find a veritable gold mine of source material for a television show in the heart-warming dramatization of what the medical profession is doing daily to prevent any occasion for bona fide heartbreak cases.

ILO Convention Not Approved by Administration

President Eisenhower sounded a reassuring note recently when he forwarded to the Congress, with a recommendation that it not be ratified, the controversial convention of the International Labor Organization on minimum standards of social security. In his message he stated that most of the points, including a suggestion for socialized medicine, were not proper subjects to be dealt with by the Congress.

The convention, adopted by ILO in 1952, has caused concern in medical and other groups, as explained in an editorial entitled "ILO — Danger Ahead!" in the October 1952 issue of The Journal. As pointed out there, it covers nine fields: medical care, sickness benefits, unemployment benefits, old age benefits, employment injury benefits, family benefits, maternity benefits, invalid benefits, and survivor benefits. A government is considered to have ratified the convention

if it promises to meet the requirements in three of the nine fields.

The medical care section stipulates that a country may qualify as ratifying if it agrees to provide one of the following: (a) a system of compulsory health insurance, (b) private, voluntary health insurance "administered by public authorities under established regulations" set by law, or (c) private, voluntary health insurance administered by insurance companies but under government "supervision." Half the population would have to be covered.

In his message of transmittal to the Congress, the President said the convention "is . . . regarded as not suitable for ratification but rather for referral to the appropriate federal and state authorities for their consideration." In an accompanying summary of comment from all affected federal departments and agencies it was explained that federal laws already are in accord with two of the points, old age insurance and survivors insurance. On the other points, the agencies concurred in the President's conclusion, namely that these issues are within the jurisdiction of state governments, and "that therefore the convention is not appropriate for ratification" by the Congress. It was also noted in the summary that while signatories to the convention agreed to bring it before their respective legislative bodies, "it is entirely within the discretion of the competent authority of each country to determine whether any legislation is to be enacted." The brief was concurred in by the Commerce, Interior, Justice, Labor, Navy, and Health, Education, and Welfare Departments, and by the Civil Service Commission.

ILO continues to spell danger, but the administration's attitude on this undisguised effort to point this country in the direction of socialized medicine is gratifying. The international route to fulfilment of the socialist's dream is as much to be avoided as the national route. Socialism by treaty is no more desirable, and no less binding under present laws, than socialism by domestic legislation.

Registration of F. M. A. Members at A. M. A. Convention San Francisco, June 21-25, 1954 will appear in your September Journal

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Just Between Neighbors
Unique Medical Care Study

Petit Jean mountain in Arkansas bids fair to become a landmark in American medicine. It stands to gain this distinction because a newcomer to the mountain, unannounced and virtually unknown, walked next door for a visit. A smile and a friendly handshake between the new resident, Winthrop Rockefeller, multimillionaire oil heir, and his neighbor, Dr. Louis K. Hundley, chairman of the Council of the Arkansas Medical Society, resulted in a close friendship and sparked a long and serious discussion which led to a half million dollar medical care study believed to be unique in this country.

Recently, Mr. Rockefeller announced that he would finance a proposed project aimed at aiding backwoods communities to help themselves in obtaining more adequate medical care through more effective organization and use of present state medical facilities. The project already has the approval of the Arkansas Medical Society's House of Delegates and of the Arkansas Academy of General Practice. Also, Gov. Francis Cherry has pledged state cooperation.

One of the project's two units will be a pilot clinic in an Arkansas area now without adequate medical service. Residents of the area will obtain medical care at the clinic. The other will be a research unit which, from observations of the clinic, will seek answers to questions puzzling to the medical profession for years. They include:

1. Can such a community or area support a medical unit?

2. If it cannot support one on a fee basis, could it support one on a prepayment basis?

3. If the area needs and can support medical care, why isn't there a doctor there now?

4. What level of medical service can be provided by the "minimum type" clinic plan?

5. Where and how far will residents of the area have to go to obtain care which cannot be provided by the minimum clinic?

"This won't be a plush set-up by any means," Dr. Hundley said. "The clinic's staff will consist of one doctor, a nurse or receptionist, and maybe a technician. It won't be a hospital — more like a doctor's office. There will be no beds. The only operations performed will be emergency ones." Neither will the clinic provide free medical care. Fees will be charged for the doctor's services and

for use of clinic facilities. "Mr. Rockefeller made it clear," Dr. Hundley added, "that, while he will finance the start of the clinic, he expects it to be self-supporting within three to five years."

This study should evoke wide interest on the part of the medical profession as a constructive venture in free enterprise in the interest of adequate medical care for all. It affords a pleasing contrast to turning to the government to promote such a project. Thanks to the neighbors on Petit Jean mountain, medicine takes another forward step.

House Exempts Physicians From Social Security Coverage

Articulate physicians evidently caused the House Ways and Means Committee to reverse itself on the compulsory coverage of physicians before voting out the social security extension bill, which was passed by the House by a vote of 355 to 8 on June 1 and sent on to the Senate. By a vote reported as 12 to 8, the committee on May 19 agreed to force coverage on physicians. There followed a flood of telephone calls and telegrams from state medical societies and individual physicians opposing compulsion. Before completing action on the bill and reporting it favorably to the House on May 25, the committee reconsidered its action and by a vote of 15 to 10, representing the full membership, decided not to extend coverage, either compulsory or voluntary, to physicians, interns or student nurses.

The protests against mandatory coverage from medical societies and physicians undoubtedly had much to do with this reversal and probably were the decisive factor. Not every physician, of course, is opposed to social security, but the widespread objections which poured in offered evidence to the committee that the opposition of the American Medical Association to the compulsory feature has the ardent and articulate support of many, many physicians.

The bill at this writing is before the Senate Finance Committee, where anything can happen. The committee has been informed that the American Medical Association does not oppose voluntary coverage of physicians.

Medical Care Cost How Much of a Problem?

A favorite contention of critics of the medical profession is that increased medical costs are proving financially disastrous to families faced with illness or accidents. No one will deny that medical costs, along with all other costs, have risen in recent years. Nevertheless, according to statistics presented by the United States Department of Labor for the third quarter of 1952, living costs had increased 90.8 per cent since 1935-1939 while in the same period medical costs had increased only 65.5 per cent. In addition, between 1935-1939 and 1950 average weekly wages rose 165 per cent while physicians' fees climbed only 48 per cent. The average person, therefore, works only 60 per cent as long today to pay for the same amount of medical services.[1]

Aided by new technics and new drugs, physicians are able to reduce the length of illness and of the period of hospitalization as well as wage loss. In consequence, for many illnesses the total medical bill may actually be less than it was 15 years ago.

Did you know there is proof that the cost of medical care presents no great problem to the majority of American families? A survey completed for the Federal Reserve Board last year disclosed that almost 43,000,000, or over 80 per cent, of some 53,000,000 families in the United States reported no medical debts whatsoever. One million families owed from $200 to $1,000, while another 200,000 owed more than $1,000. These figures indicate then that less than 3 per cent of all the people in the survey need help to pay their medical bills. The indebtedness of the remaining 9,000,000 families for medical expenses varied in amount from $1 to $200. These statistics from government sources should be satisfying to any critic who wishes to be convinced of the facts. One wonders how these figures would compare with the corresponding figures on indebtedness for nonessentials.

1. Our Positive Program, an address presented by Walter B. Martin, M.D., President-Elect, AMA, to the Committee on Interstate and Foreign Commerce, House of Representatives, January 28, 1954.

Care in Mailing Blood Specimens

Postal authorities have directed attention to the careless manner in which many blood specimens are mailed. The common practice of mailing blood specimens collected in glass vials and packed in metal screw-topped containers to private and governmental laboratories for various tests is not objectionable to them. The complaint comes from a number of postal centers, however, that because in many instances the caps of the metal containers are not screwed on securely, the vials slip from the tubes. When they are broken, the blood stains other mail, as well as being a loss to the sender and his patient. It has happened a number of times that several specimens in one batch of mail have come out of their containers. Which specimen came from which tube obviously became a riddle beyond solving by the postal authorities, important as the correct solution was to the senders.

Screwing the caps on securely is apparently not enough. Postoffice officials urge that physicians or their technical assistants place a strip of adhesive, preferably not the transparent plastic type, across the top and extend it down the sides of the container. Forethought and cooperation in this matter will be beneficial to all concerned.

Polio Vaccine Trial Needs Physicians' Aid As It Moves Into Evaluation Phase

More than 600,000 children have completed three inoculations, in the field test of the trial polio vaccine developed by Dr. Jonas E. Salk of the University of Pittsburgh. The emphasis now shifts to the evaluation study under the direction of Dr. Thomas Francis Jr., University of Michigan School of Public Health. The validity of the evaluation is dependent upon data gathered on poliomyelitis cases in the test groups, including those children in the first three grades who did not get vaccine.

In addition, data on cases among family members of participating children are an integral part of the study. Since the number of poliomyelitis cases among the test groups may not be large, it is essential that all cases are completely reported. Early diagnosis, prompt reporting and follow-up, and the securing of necessary epidemiological information and laboratory specimens are important factors in the evaluation.

An outline of procedures and copies of necessary forms have been sent to local and state health authorities. It is important that physicians in areas where vaccinations were not given cooperate in the study by notifying local or state health officers of cases occurring among children who participated in the trials and then migrated to another area and children who go to summer camps. Local health officials also need information on participating children who receive injections of Gamma Globulin.

This phase of the study will depend, to a large degree, on the wholehearted cooperation of practicing physicians.

Graduate Medical Education Diabetes Seminar October 21-22

The Florida Clinical Diabetes Association will hold its second annual meeting at the San Juan Hotel in Orlando on October 21-22, 1954. Guest speakers are: Dr. H. B. Mulholland, University of Virginia School of Medicine, Charlottesville, Va., and Dr. Joseph T. Beardwood Jr., Philadelphia. Member speakers are: Dr. Richard H. Sinden, St. Petersburg; Dr. Edward R. Smith, Jacksonville; Dr. Turner Z. Cason, Jacksonville; and Dr. Joseph J. Lowenthal, Jacksonville. In addition to presenting the lectures scheduled in the program, Dr. Beardwood will address interested physicians and laymen on the subject of employment of persons with diabetes mellitus. Dr. Beardwood is a member of a national committee which is putting forth every effort to interest business firms in employing persons who have this disease. The program appears on the opposite page.

Tentative arrangements have been made for the course in Hematology to be held in Jacksonville at the George Washington Hotel, November 18-20. Dr. William Dameshek, Director, Blood Research Laboratory, New England Center Hospital, Boston, will give the major portion of the lectures and demonstrations and will be ably assisted by distinguished associates whom he will designate. The detailed program will be announced later in The Journal.

PROGRAM

DIABETES SEMINAR

THURSDAY, OCTOBER 21 Moderator — Dr. Fred Mathers, President

8:30- 9:15	Registration	
9:15-10:15	"Diabetes — Its General Management"	Dr. Mulholland
10:15-11:15	"Diabetic Ketosis, Treatment and Prevention"	Dr. Beardwood
11:15-11:30	Recess	
11:30-12:15	"Radioactive Isotopes in the Diagnosis and Treatment of Thyroid Disease" Moderator — Dr. Eugene L. Jewett, President, Orange County Medical Society	Dr. Mulholland
2:00- 2:30	"New Views on Pathology of Diabetes"	Dr. Beardwood
2:30- 3.00	"Some of the Complications of Diabetes"	Dr. Mulholland
3:00- 3:15	Recess	
3:15- 4:00	"Preoperative and Postoperative Care of the Diabetic Patient"	Dr. Mulholland
4:00- 4:30	"Neurologic Lesions as Observed by the Clinician"	Dr. Sinden
4:30- 5:00	"Use of Corticoptropic Hormones in Diabetes"	Dr. Beardwood
6:30	Dinner Meeting of the Association (Election of Officers)	

FRIDAY, OCTOBER 22 Moderator — President-Elect

9:00- 9:30	"Indications For Various Insulins and Their Use"	Dr. Mulholland
9:30-10:15	"Hemochromatosis, Newer Concepts in Etiology and Treatment"	Dr. Beardwood
10:15-10:30	Recess	
10:30-10:50	"Incidences of Diabetes in Florida as Determined by Mass Survey"	Dr. Smith
10:50-11:10	"Twenty-Five Years' Clinical Practice of Diabetes"	Dr. Cason
11:10-12:00	"Cardiovascular Complications"	Dr. Mulholland
12:00-12:30	"Life and Emotional Stresses of the Diabetic Patient" Moderator — Dr. Sidney Davidson, Incoming President	Dr. Lowenthal
2:00- 3:00	"The Juvenile Diabetic Patient"	Dr. Beardwood
3:00- 3:15	Recess	
3:15- 4:15	Panel Discussion— Dr. Mulholland, Dr. Beardwood, Dr. Sinden, Dr. Smith, Dr. Cason, Dr. Lowenthal	
8:00	Public Meeting	

OTHERS ARE SAYING

"It Can't Happen to Me"

This has to do with waste. Waste of skill hard to acquire. Skill much in demand because it is so vital to humans.

We doctors possess that skill, having achieved it at great cost to ourselves and the community. Most of us pass it along selflessly, which is to our credit; but we neglect ourselves in doing that job and that is to our discredit.

We don't self-apply those basic rules for good health that we daily drum into our patients. We don't practice what we preach. By some peculiar distortion we consider ourselves above the need for a health inventory until it's too late.

We procrastinate, whether through fear or carelessness, until an imminent breakdown moves us to action. This has the appearance of self-sacrifice. It isn't that at all; it's sheer waste.

When we fall into unhealthy habits, when we fail to have ourselves screened regularly for remediable defects, we undermine a service that belongs to the public, shortening its expectancy and hampering its efficiency. And we lose years of comfortable living in the process.

We should stop this wastefulness. There are no obstacles to our doing what we advise others — only indolence and the false notion in each of us that it can't happen to me.

Wm. S. Reveno, M.D. (Associate Editor)
—Detroit Medical News, April 19, 1954

Cancer, Communism and the Age of Suspicion

Nowadays we hear much about the corroding effects of suspicion on the body politic. There is a disease — communism — as malignant in the political body as is cancer in the human body. Whether or not a healthy degree of suspicion is necessary to eradicate this foul blight we will leave to others, but one thing we do know — a higher index of suspicion among the medical profession would lead to earlier diagnosis and treatment of many cases of cancer.

Unfortunately, lay people to a great extent and physicians to some degree, seem to believe that expensive and elaborate equipment are needed to diagnose cancer. There is no greater fallacy. While special diagnostic techniques are needed to search out inaccessible growths, nevertheless, employing only the simplest instruments and with the aid of the invaluable equipment God has given to every doctor — brains, eyes and hands — we can diagnose in the earliest stages cancers of the skin, breast and all the body orifices.

For cancer, at least, let's make this an age of suspicion!

—Westchester (New York) Medical Bulletin, April 1954

What a Physician Should Be

When a man has been in private practice for more than 25 years and has made a success of it, you might think he would have some good advice for those who have still to set out on their careers. You'd be right in the case of Dr. Julian Price of Florence, South Carolina. Recently, he had occasion to talk extemporaneously to a group of medical students. He had no manuscript — not even a note — and his speech was not recorded. Here's approximately what Dr. Price had to say about what a physician should be.

First, a physician should be well trained. Nowadays, the medical schools and internships and residencies take good care of that. When a doctor is ready to start practice, the chances are he's well prepared scientifically.

Second, the kind of physicans worth having are those who will keep up with scientific and other advances in medicine. There are plenty of opportunities for them to do this — good medical journals and fine meetings — but often there is insufficient motivation. It's so easy not to keep abreast; there are so many distractions that you must kick yourself to make you do it.

Third, a doctor needs a large amount of the spirit of skepticism. There's a tendency during training days in school and just afterward for

doctors to think that their stock of information is without parallel. They know it all. Fortunately, most of them outgrow this tendency, at least to some extent. This may come about when a doctor suddenly realizes that an authoritative source for information like a brand new textbook is far out of date when it's first published. Or skepticism may be fostered when the unexpected happens. An example is the case of the young resident who was instructed by his professor to administer Mercurochrome intravenously to a patient having puerperal sepsis. (This was in the days before there were any good chemotherapeutic agents for such infections.) A couple of days later the patient's temperature was normal and she was much improved. Seeing her again on ward rounds, the professor was elated. He exclaimed, "It worked!"

"What worked?" asked the resident.

"The Mercurochrome, of course," replied the professor.

"Oh that," said the resident, "I forgot to give it."

In some kinds of practice in some places, skepticism is especially important. Certainly that's true in pediatrics, particularly in the "sticks." So, keep a question mark in your mind all the time. Don't ever suppose that the final answer is in.

Fourth, doctors need to be patient-minded. It's a common criticism that doctors think too much about their own comfort and welfare and the money they make, and not enough about their patients. We need doctors who think primarily of their patients. Remember, when a doctor responds to a patient's call at 2:00 a.m., that's not news; when he doesn't, that is news!

Fifth, doctors must have character. It's easy for a physician to pull a fast deal, to get away with untruths, to be not exactly honest. An example we hear about now and then is the doctor who gets caught in an attempt to evade payment of income tax. Fortunately there are not many crooked doctors. But there is a small group who give the profession a black eye. We need to get rid of them, and we need to be sure that newcomers to the profession are men of integrity and character.

Sixth, the medical profession should be made up of men who are not afraid to take their place in the community. Our Nation is founded on community life. This has advantages for all of us, and it creates special obligations for some of us. Those in the medical profession must remember that they are not just physicians — they are citizens too. The average medical student never thinks about this, but when he goes into practice he must do his part as a citizen in support of schools, the Boy Scouts, philanthropic organizations, and all the other parts of life in the community in which he lives and practices. The attitude of other people toward the medical profession depends upon what individual physicians do in their practice, but it also depends upon what these men contribute as citizens.

Editorial comment on Dr. Price's remarks would be gild for the lily. Let this end with the thought that Dr. Price does more than talk about things like these. His career in medicine is a vital example of what a physician should be.

H. H. H.

—Medical Annals of the District of Columbia, April 1954

Civic Responsibilities

As physicians we owe much to our communities. One way in which we may discharge our obligation is to accept the civic responsibilities and duties which any leading citizen should assume. Being busy practicing physicians is of itself a very good reason why we should devote some of our time and effort and influence to the good activities of our locality. The churches, the schools, the civic clubs, the charitable activities and, by all means, the local government deserve our support.

Probably no medical public relations activity would be necessary if most of the medical practitioners of the United States would take active part in their local affairs. Such things as "grass roots" conferences and influence would never have been needed if we doctors would express ourselves clearly and firmly on questions of local importance.

The professional and personal conduct of physicians should be above reproach. In lay or professional meetings, or indeed anywhere at any time, our own conduct reflects impressions of medical men as a whole. Only we can make sure these impressions are favorable. Do not allow unfavorable remarks to be made about all physicians because your actions or mine were questionable.

Our local community leaders have the opinion of organized medicine that we have given them by deed or by example.

—The Journal of the Arkansas Medical Society, April 1954

Hazards to Our Kind of Medicine

With Gov. Earl Warren, a vigorous proponent of socialized medicine, added to the Supreme Court, and with the failure of the Bricker amendment, American medicine has had two possible strikes against it — not imminent or urgent, but maybe insidious.

—The Journal of the South Carolina Medical Association, April 1954

BIRTHS AND DEATHS

Births

Dr. and Mrs. Leo M. Levin of Miami Beach announce the birth of a daughter, Adrienne Dale, on March 5, 1954.

Dr. and Mrs. Jacob Kaufman of Miami announce the birth of a son, Michael Roy, on May 19, 1954.

Dr. and Mrs. Edward J. Clark of Jacksonville announce the birth of twin daughters, Sandra Lynn and Lorraine Sidney, on May 19, 1954.

Dr. and Mrs. Stanley Margoshes of Miami announce the birth of a daughter, Cathy, on May 26, 1954.

Dr. and Mrs. Robert M. Mein of Jacksonville announce the birth of a daughter, Mary Kathryn, on June 10, 1954.

Dr. and Mrs. W. Dotson Wells of Fort Lauderdale announce the birth of a son on June 14, 1954.

Dr. and Mrs. Seymour L. Alterman of Miami Beach announce the birth of a daughter, Karen Lenore, on June 17, 1954.

Dr. Lois E. Friedl (Mrs. Dallas Calhoun) and Mr. Dallas Calhoun of Orlando announce the birth of a daughter, Laurie Lois, on June 26, 1954.

Dr. and Mrs. Andre S. Capi of Hollywood announce the birth of a daughter, Wendy, recently.

Dr. and Mrs. G. Dekle Taylor of Jacksonville announce the arrival of a son, Jonathan Dekle, in their home.

Deaths — Other Doctors

Byle, Archie S., Fort Myers..... Feb. 22, 1954
Aber, Albert H., Pittsburgh..... March 20, 1954
Dees, Theodore A. Jr., Lake Charles, La.... March 26, 1954

Medical Officers Returned

Dr. William V. Roberts, who entered military service on Jan. 7, 1953, was released from active duty on May 25, 1954 with the rank of lieutenant commander (U. S. Navy). His temporary address is C/O J. B. Roxton, South Atlantic Bank, Sanford.

Dr. Daniel H. Mathers who entered military service on Sept. 29, 1941, was released from active duty on May 1, 1954 with the rank of commander, U. S. Navy. His temporary address is C/O C. A. Woodham, Box 166, Winter Haven.

CORRESPONDENCE

Florida Society of Anesthesiologists
May 1, 1954

Shaler Richardson, M.D., Editor
Journal of the Florida Medical Association
P.O. Box 1018
Jacksonville, Florida

Dear Dr. Richardson:

In April 1951 the Florida Society of Anesthesiologists organized a special committee known as the Anesthesia Study Commission. The purpose of this commission is to "help us help each other," the idea being to avoid repetition of errors of omission or commission which result in fatalities during the induction of anesthesia during the operation, or in the first few hours postoperatively.

For the past four years members of the Florida Society of Anesthesiologists voluntarily sent in case reports of fatalities to the Anesthesia Study Commission for analysis. Cases were presented anonymously at our meetings, and the opinion of the members was sent to the referring anesthesiologist.

On April 25, 1954, the Florida Society of Anesthesiologists, at its annual meeting in Hollywood, Florida, recommended that the above service be extended to all physicians in the state of Florida.

The Anesthesia Study Commission requests the names, dates and places be omitted in the case reports. A summary of opinions will be mailed to the referring physician.

As chairman of the Anesthesia Study Commission of the Florida Society of Anesthesiologists I would greatly appreciate dissemination of this information to the physicians of Florida, through The Journal of the Florida Medical Association.

Please address all communications to B. L. Steinberg, M.D., Chairman, Anesthesia Study Commission, 1230 97th St., Miami Beach.

Sincerely yours,

(signed) B. L. Steinberg, M.D.
Chairman, Anesthesia Study Commission

STATE NEWS ITEMS

Plans are now underway for the preparation of the Scientific Program for the Eighty-first Annual Meeting of the Florida Medical Association to be held in St. Petersburg, beginning April 3, 1955.

It is most desirable that the high quality of the previous programs be continued. In order to do this, your committee must have many papers on a wide range of subjects. It is, therefore, urged that you submit any proposed papers together with a brief resume of the subject to be discussed to the committee at an early date.

Applications must be received by early November, 1954, and should be mailed to Chas. J. Collins, M.D., Chairman, Scientific Work Committee, 1503 Kuhl Ave., Orlando.

Specialty groups desiring their speakers on the state program must advise the Scientific Work Committee by November also.

Dr. C. Ashley Bird of Jacksonville attended the meeting of the American Neurological Association in Washington, D. C., in April.

Dr. Bird was on the panel of neurosurgical consultants at the summer meeting of the Savannah Medico-Legal Institute at the General Oglethorpe Hotel, Savannah, Ga., June 7-9, 1954.

The Florida State Alcoholic Rehabilitation Program is conducting a survey for a professional program in alcoholism. One of the members of the advisory committee is Dr. Wilson T. Sowder of Jacksonville.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Bracken, John S., Sarasota
Eversole, Joseph W., Jacksonville
Freeman, Oscar W., Orlando
Garrett, Samuel R., Winter Haven
Gibson, Joseph A., Bradenton
Jaffe, Norman, Miami
Rentz, Billy P., Miami
Shepard, Vitol S., West Palm Beach
Szabo, Imre, Orlando

Dr. David W. Goddard of Daytona Beach spoke at a meeting of District 6, Registered Professional Nurses of the Florida State Nurses Association, on May 18.

Dr. Joseph S. Stewart of Miami was speaker at the University of Georgia commencement exercises on June 4 in Athens, Ga.

Dr. Theodore J. Kaminski of Melbourne spoke to the Melbourne-Eau Gallie Ministers' Association on "Cooperation in the Care of the Sick," in May.

Dr. Fred E. Brammer of Dania spoke on "The Challenge of the Future in Tuberculosis Control," at a dinner meeting of the Broward County Tuberculosis and Health Association in May.

Dr. Edward R. Annis of Miami spoke on "Go Slower and Live Longer," at a meeting of the Miami Shores Men's Club in June.

Dr. William C. Thomas Jr. of Gainesville spoke on the heart and heart disease at a weekly luncheon meeting of the Kiwanis Club of that city in June.

Dr. Thomas left Gainesville in July to begin specialized study in the fields of arthritic and metabolic diseases at the Johns Hopkins University. He was selected by the National Institute of Public Health for a two year fellowship.

Dr. Eaton G. Lindner of Ocala recently attended the fiftieth reunion of his graduating class at the University of Cincinnati. Dr. Lindner received his degree from Miami Medical College which was merged with the Medical College of Ohio to become a part of the University of Cincinnati in 1905. Dr. Lindner has been practicing in Ocala since 1906.

Dr. Oscar L. Kelley of Palm Beach attended the third annual business meeting of the American College of Cardiology in Chicago recently.

Dr. J. Sudler Hood of Clearwater was guest speaker at the regular meeting of the Largo Rotary Club on May 24. He spoke on heart diseases.

Dr. John H. Kay of Panama City spoke to Division No. 5, Licensed Practical Nurses, on May 28 on "The American Cancer Society and Its Functions."

Dr. William W. Miller Jr. of Pensacola was elected chairman of the Escambia County Children's Committee at a meeting held May 24.

Dr. John M. Gunsolus of Stuart spoke to representatives of six P.-T.A.'s from Martin and Okeechobee Counties at a bi-county council meeting in Indiantown in May. He cited the need for more aid for the mentally ill of Florida.

Dr. J. M. Ingram Jr. of Tampa attended the meeting of the American Gynecological Society in Hot Springs, Va., and visited Duke University School of Medicine in Durham, N. C., recently.

Dr. James B. Leonard of Clearwater was guest speaker at the monthly meeting of the upper West Coast group of the Florida Medical Record Librarians in May. His subject was "Present Day Oncology."

Dr. Paul J. McCloskey of Tampa recently presented the Elks Club trophies and the Dr. James Estes Memorial award to the outstanding lineman, outstanding back, and outstanding senior athlete, respectively, at a banquet in honor of the University of Tampa football and basketball players.

Members of the Southern Society of Cancer Cytology wishing to present scientific papers at the forthcoming annual meeting of the society are requested to apply to the program chairman, Dr. Lois I. Platt, George Washington School of Medicine, 23rd St. at Washington Cir., Washington, D. C. The scientific meeting is held each year conjointly with the Southern Medical Association which will be held in St. Louis this year, November 8-11. Address inquiries concerning the Southern Society of Cancer Cytology to the secretary, Dr. J. Ernest Ayre, 1155 N. W. 14th St., Miami.

Dr. Wm. W. McKibben of Miami was given a testimonial dinner on June 11 by the Miami Pediatric Society. Dr. McKibben, who is 80 years of age, has been in continuous pediatric practice in Dade County since 1923.

Dr. Meyer B. Marks, Miami Beach, has been elected president, and Dr. Martiele Turner, Coral Gables, secretary-treasurer, of the Miami Pediatric Society.

Dr. Robert G. Nelson of Tampa was elected president of the South Atlantic Association of Obstetricians and Gynecologists at the regular meeting in January 1954.

Dr. Donald W. Smith of Miami spoke on "Lung Cancer" at a meeting of the Miami Exchange Club on June 8.

Dr. John J. Benton of Panama City was principal speaker at the weekly luncheon meeting of the Kiwanis Club of that city on June 9. Dr. Benton, who is chairman of the Board of Directors of the Bay County Child Guidance Clinic, spoke on the plans for the establishment of the clinic.

Dr. Bascom H. Palmer of Miami was presented two plaques by the Miami Rotary Club on June 10 for outstanding services to the Dade County Blood Bank and for his aid to sightless persons.

Dr. Donald H. Gahagen of Fort Lauderdale is representing the Florida Division of the American Cancer Society on the Board of Directors of the national organization.

Dr. George A. Dame of Jacksonville was elected president of the newly organized American College of Preventive Medicine at a recent meeting of the diplomates of the American Board of Preventive Medicine from several states held in St. Petersburg.

Dr. Homer L. Pearson Jr. of Miami has been elected chairman of the American Medical Association Judicial Council. Dr. Pearson has served as a member of the Council for many years.

Dr. David Sloane of Lakeland spoke at a meeting of the Florida West Coast Medical Record Librarians on June 17. His subject was "Importance of Orthopedic Records."

Dr. Richard E. Strain of Miami spoke on "Communicating Hydrocephalous as a Complicating Factor in the Surgical Treatment of Intracranial Aneurysm" at the annual Harvey Cushing meeting in Santa Fe, N. Mex.

Dr. Wesley S. Nock of Coral Gables has been elected to membership in the American Association of Medical Milk Commissions. This association makes and enforces rules and regulations for all the certified dairies throughout the country.

Dr. Leo M. Levin of Miami Beach has been elected to serve as Consul of the Phi Delta Epsilon Graduate Club.

Dr. Mozart A. Lischkoff of Pensacola was presented a special past president's button and a scroll of honor for 35 years continuous service to the Pensacola Kiwanis Club and to the community. The presentation took place on June 17.

Dr. Anthony D. Migliore of Arcadia gave a talk on mental diseases at a meeting of the Public School Nurses from Polk County on June 29 at the Florida State Hospital, Arcadia.

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COMPONENT SOCIETY NOTES

Broward

The Broward County Medical Association is holding no regular meetings during the summer months.

Dade

At the regular monthly meeting of the Dade County Medical Association on July 6, Drs. Martin G. Gould and Donald W. Smith presented a paper on "Blood Transfusions with Special Reference to Use of Plasma and Plasma Expanders."

Lake

Dr. Edward Jelks of Jacksonville was principal speaker at the meeting of the Lake County Medical Society on June 2. Dr. Jelks spoke on press relations with the medical profession, and newspaper and radio representatives from Lake and Sumter counties were invited to attend the meeting.

The regular meeting on July 7 was held at the Leesburg Elks' Club.

For the seventh consecutive year the members of the Lake County Medical Society have given physical examinations and immunizations to the Leesburg and Eustis Companies of the Florida National Guard, which have approximately 200 members.

Lee-Charlotte-Collier-Hendry

Dr. George T. Harrell, Dean of the College of Medicine at the University of Florida, was guest speaker at the meeting of the Lee-Charlotte-Collier-Hendry County Medical Society on May 24. He spoke on the new school of medicine.

Orange

At the regular monthly meeting of the Orange County Medical Society on May 19, Dr. George T. Harrell, Dean of the University of Florida Medical School, was guest speaker.

Pinellas

The Pinellas County Medical Society is not holding meetings in July and August. Next scheduled meeting will be held on September 13.

St. Lucie-Okeechobee-Martin

The St. Lucie - Okeechobee - Martin County Medical Society has paid 100 per cent of its state dues for 1954.

OBITUARIES

John Radford Boling

Dr. John Radford Boling of Tampa died at his home on April 12, 1954. He was 59 years of age and had suffered from a heart ailment for several years although he had continued his practice.

Born in Clifton, S. C., in 1894, Dr. Boling received his medical education at Emory University School of Medicine, where he was awarded the degree of Doctor of Medicine in 1915. After completing an internship at Hamot Hospital in Erie, Pa., he returned to his native state to enter the private practice of medicine at Columbia. Six years later he came to Florida to reside and located in Bradenton, where he operated the Roof Memorial Hospital until he moved to Tampa in 1929. He was a veteran of World War I, having served with distinction as a captain in a surgical mobile unit at the front in France and at Evacuation Hospital No. 9.

Specializing in surgery, Dr. Boling soon became a leading surgeon of Tampa. He was chief of staff at St. Joseph's Hospital from the time of its opening and was largely responsible for its success and growth. He also served for some time as chief of the surgical staff of the Tampa Municipal Hospital and the Clara Frye Tampa Municipal Negro Hospital, and for many years was local consulting surgeon for the Atlantic Coast Line Railway. He was a member of the Baptist Church, a Mason, a Shriner, a Rotarian and a former member of the Tampa Yacht and Country Club and of the Palma Ceia Golf Club.

Prominent in state and national medical circles, Dr. Boling was a past president of both the Manatee County Medical Society and the Hillsborough County Medical Association. During the 29 years that he held membership in the Florida Medical Association, he rendered distinguished service in various official capacities and climaxed his official duties by serving as its president in 1944 and 1945. He was a Diplomate of the American Board of Surgery, a Fellow of the American College of Surgeons, a Fellow of the International College of Surgeons, and a member of the Southeastern Surgical Congress, the Southern Medical Association and the American Medical Association. One of the founders of Florida's Blue Cross-Blue Shield Health Plans, he served continuously as a director until his death. Also, he was a contributor to various medical journals.

Surviving are the widow, Mrs. Mary Ethel Boling, of Tampa; two sons, John Radford Boling Jr., of Tampa, and Dr. Davis Spratlin Boling, of Atlanta, Ga.; and one daughter, Miss Katherine Boling, of Atlanta.

David Ross Kennedy

Dr. David Ross Kennedy of Paducah, Ky., a former resident of Sarasota, died on March 24, 1954 in Paducah. He was 58 years of age. Interment took place in Due West, S. C.

A South Carolinian by birth, Dr. Kennedy was born in Due West in 1895. He received his medical training at the Jefferson Medical College of Philadelphia, where he was graduated in 1921. He then served an internship at Pennsylvania Hospital in Philadelphia.

Dr. Kennedy was licensed to practice medicine in Florida in 1924 and for almost 30 years engaged in the general practice of medicine and surgery in Sarasota. Late in 1953 he left Sarasota for Paducah, where he was associated with a hospital at a government atomic energy project in the Kentucky city. He was a member of the Whitfield Estates Presbyterian Church in Sarasota.

Dr. Kennedy was a member of the Sarasota County Medical Society, and since 1925 had held membership in the Florida Medical Association. He was also a member of the American Medical Association.

Survivors include one daughter, Miss Carolyn Kennedy, a registered nurse, of Sarasota; two brothers, Dr. John P. Kennedy, a Charlotte, N. C., surgeon, and Seldon Kennedy, of Due West; and three sisters, Miss Julia Kennedy, of Clinton, S. C., Mrs. Nat Smith, of York, S. C., and Mrs. Frances White, of Spartanburg, S. C.

(Continued on page 138)

Amebiasis[1] a "Poorly Reported" Disease

Until serious complications arise, amebiasis may pass unrecognized and patients receive only symptomatic treatment.

Although amebiasis is a disease with serious morbidity and mortality, statistics on its incidence[1] are incomplete because its manifestations are not commonly recognized and consequently not reported.

"*Vague symptoms[2] referable to the gastrointestinal tract, such as indigestion or indefinite abdominal pains, with or without abnormally formed stools, may result from intestinal amebiasis. Not infrequently in cases in which such symptoms are ascribed to psychoneurosis after extensive x-ray studies have been carried out, complete relief is obtained with antiamebic therapy.*"

To prevent possible development of an incapacitating or even fatal illness and to eliminate a reservoir of infection in the community, diagnosing and treating[3] even seemingly healthy "carriers" and those having mild symptoms of amebiasis is advised.

Early diagnosis[1] is important because infection can be rapidly and completely cleared, with the proper choice of drugs and due consideration for the principles of therapy. For treatment of the bowel phase these authors find Diodoquin "most satisfactory."

For chronic amebic infections, Goodwin[4] finds Diodoquin to be one of the best drugs at present available.



Endamoeba histolytica (trophozoite).

Diodoquin, which does not inconvenience the patient or interfere with his normal activities, may be used in the treatment of acute or latent forms of amebiasis. If extraintestinal lesions require the use of emetine, Diodoquin may be administered concurrently. It is a well tolerated and relatively nontoxic orally administered amebacide, containing 63.9 per cent of iodine.

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1. Hamilton, H. E., and Zavala, D. C.: Amebiasis in Iowa: Diagnosis and Treatment, J. Iowa M. Soc. *42*:1 (Jan.) 1952.

2. Goldman, M. J.: Less Commonly Recognized Clinical Features of Amebiasis, California Med. *76*:266 (April) 1952.

3. Weingarten, M., and Herzig, W. F.: The Clinical Manifestations of Chronic Amebiasis, Rev. Gastroenterol. *20*:667 (Sept.) 1953.

4. Goodwin, L. G.: Review Article: The Chemotherapy of Tropical Disease: Part I. Protozoal Infections, J. Pharm. & Pharmacol. *4*:153 (March) 1952.



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(Continued from page 136)

Raul Roque de Escobar

Dr. Raul Roque de Escobar of Tampa was apparently the victim of mental depression which caused his death on March 7, 1954. He was 48 years of age and had been in ill health for some time.

Born in Key West on Sept. 11, 1905, Dr. Roque received his early education there, attending St. Joseph's Catholic School for boys and the Monroe County High School. Upon completion of his premedical training at the University of Florida, he attended the University of Tennessee College of Medicine, where he received his medical degree in 1932. He then served an internship at Danbury, Conn., before returning to his native state to locate in Tampa. He engaged in medical services for several hospital clinics until 1940 when he established himself in private practice.

Locally, Dr. Roque was a member of the staff of the Tampa Municipal Hospital and the Clara Frye Tampa Municipal Negro Hospital. He was the attending physician for the Mary Help of Christians School and orphanage, of which he was a liberal supporter. During World War II he was examining physician for the local draft board No. 3. He was a member of the Sacred Heart Catholic Church, and also held membership in the Elks Lodge 708 and the Davis Island Tennis Club.

Dr. Roque was a member of the Hillsborough County Medical Association. Since 1946 he had been a member of the Florida Medical Association, and he also held membership in the American Medical Association.

Surviving are the widow, Mrs. Josephine Scaglione Roque, and one son, Raul Roque Jr., of Tampa.

Howard Grey Holland

Dr. Howard Grey Holland died at his home in Leesburg on Feb. 13, 1954. He was 57 years of age and had been in ill health for a number of years.

A native of Headland, Ala., Dr. Holland was born there in 1896. In 1923, he received the degree of Doctor of Medicine from Emory University School of Medicine. He then served an internship and a residency at Grady Hospital in Atlanta.

In 1925, Dr. Holland located in Leesburg, where he engaged in the general practice of medicine. In 1932 he gave Leesburg its first hospital, which he replaced in 1947 with the Theresa Holland Hospital and Clinic, a quarter-million dollar institution named for his mother. Overworked during the war years, he suffered a heart attack in 1944, later resumed his practice, and when permanent retirement became necessary several years ago, he continued to head the hospital until he sold it a year before his death. Locally, he was a charter member of the Rotary Club and the Elks Club. He was a Mason and a member of the Shrine, the Order of Eastern Star and the Knights of Pythias. He held membership in the Morrison Memorial Methodist Church and served on its building committee. He was a colonel on the staff of former Gov. Spessard Holland.

Dr. Holland was a member of the Lake County Medical Society, and for 28 years had been a member of the Florida Medical Association. He was a member of the Florida Board of Medical Examiners and also held membership in the American Medical Association.

He is survived by his widow, Mrs. May Holland, of Leesburg; one son, Jerry T. Holland, of Madison; one brother, Robert Holland, of Center Hill; and two grandchildren, Howard Grey Holland II and Jerry Anne Holland, of Madison.

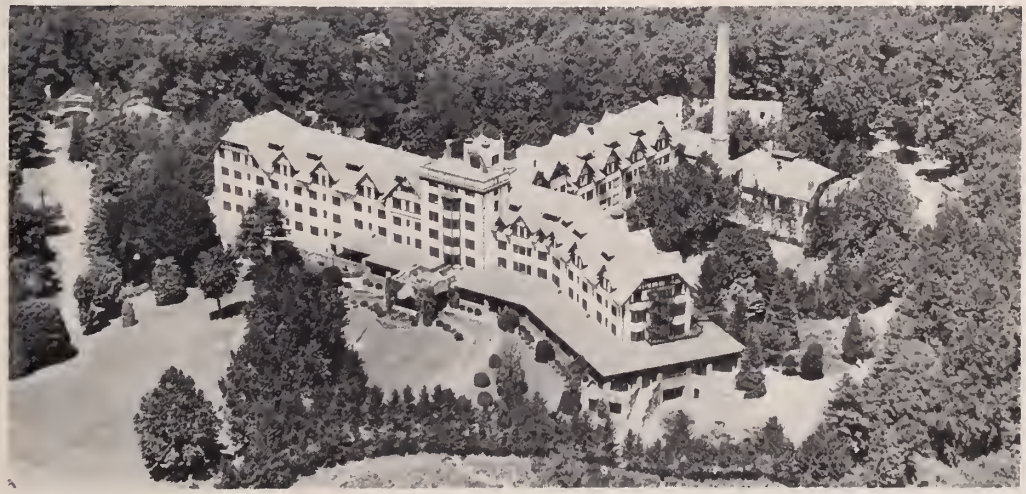
Francis Adelbert Gowdy

Dr. Francis Adelbert Gowdy of Fort Pierce died at Fort Pierce Memorial Hospital on April 6, 1954, following a lengthy illness. He was 82 years of age. Interment took place in Miami.

Born in 1871, Dr. Gowdy was graduated from the Hahnemann Medical College and Hospital in Chicago in 1896. He spent some time in surgical work at the Mayo Clinic, Rochester, Minn. In 1918, he received his license to practice in Florida. Prior to locating in Fort Pierce in 1938, he had enjoyed an extensive practice of medicine and surgery in the Miami area. Prominent in medical circles in the Fort Pierce community, he was a member of the medical board of the local hospital. He held membership in the Fort Pierce Rotary Club, and the Woodmen of the World in Sidney, Wis. A Shriner, he was affiliated with Mahi Temple in Miami.

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Dr. Gowdy was a charter member of the Dade County Medical Association. During the years of his residence in Fort Pierce, he was a member of the St. Lucie-Okeechobee-Martin County Medical Society. Since 1925 he had been a member of the Florida Medical Association, holding honorary status for the last three years. He was also a member of the American Medical Association.

Surviving are the widow; four brothers, Dr. R. A. Gowdy, of Los Angeles, Calif., Guy E. Gowdy, of Miami, and George A. Gowdy and Orville M. Gowdy, of Big Falls, Minn.; one sister, Mrs. William Undlund, of Pine River, Minn.; eight grandchildren and two great grandchildren. Two daughters preceded him in death.

Walton Clemmons Touchton

Dr. Walton Clemmons Touchton of Avon Park died at his home on April 9, 1954, following an illness of three weeks. He was 66 years of age.

A native of Stockton, Ga., where he was born in 1887, Dr. Touchton was educated in his native state. After graduation from the Atlanta School of Pharmacy, he received his medical training at Emory University School of Medicine and was awarded the degree of Doctor of Medicine in 1914.

That same year, he came to Florida to reside and located in Avon Park. For 33 years he engaged in the general practice of medicine there before retiring in 1947 to devote his time to his varied interests, including citrus groves, a ranch specializing in Brahman cattle, and a chain of drug stores in several Florida cities. He was a member of the First Baptist Church of Avon Park and a former member of the Egypt Temple Shrine of Tampa.

During the years of his active practice Dr. Touchton was affiliated with a number of medical organizations. He was a member of the DeSoto-Hardee-Highlands-Glades County Medical Society and an honorary member of the Tri-County Medical Association. For 31 years he was a member of the Florida Medical Association, and he also held membership in the American Medical Association and the Association of Seaboard Air Line Railway Surgeons.

Survivors include the widow, Mrs. Hattie Green Touchton, of Avon Park; two sons, Edward G. Touchton, of Avon Park, and Walton C. Touchton Jr., of Daytona Beach; one daughter, Mrs. Herbert Todd, of Avon Park; one brother, Charles F. Touchton Sr., of Dade City; one sister, Mrs. R. O. Martin, of Memphis, Tenn.; and six grandchildren.

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In Viewing the VA Medical Program . . .

average
length of stay in VA hospital

	Average (days)	World War II (days)	World War I & Other (days)
TB	205.8	203.6	210.2
NP	178.3	89.2	430.6
GMS	30.8	23.5	42.5

The average length of stay in VA hospitals for World War I veterans is considerably greater than for World War II veterans, which now comprise 76% of the total veteran population. The greatest pressure is yet to be exerted on VA hospitals as World War II veterans grow older and require increased medical care for disabilities unrelated to military service.

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Florida Makes Fine Showing at National Convention

It was with a good bit of pride in the home state that the president of the Woman's Auxiliary to the Florida Medical Association stood on the floor of the opening session of the annual convention of the Woman's Auxiliary to the American Medical Association and reported 100 per cent of the Florida delegation present and also five alternates present. It turned out at the end of the roll call that Florida was one of three states having 100 per cent of her delegation present and the furtherest from the convention city.

Preceding the opening session a Florida Breakfast was held in the Camellia Room of the Fairmont Hotel with 19 Florida gals sitting down together for California grapefruit, ham and eggs and sweet rolls and coffee. The Florida delegation, all 19 of us, then went together to the session. One of the delegates from Mississippi was heard to comment that she didn't know how they did it in Florida but "that bunch really stuck together and surely had fun."

The reports showed that Florida had upheld her reputation during the administration of Polly Kenaston and had done her share in all of the projects of the auxiliary. The Florida report on Today's Health showed that the Auxiliary had the third place in percentage, 153 per cent or 2075 9/12 credits. Kansas and Arizona, respectively, held first and second place with 161 per cent and 157 per cent. Our share of $1,072 in the American Medical Education Foundation helped make up the $56,000 reported as the total for the auxiliaries throughout the United States. In nurse recruitment, mental health (several people from other states were asking how we managed the beauty shop for the new woman's receiving hospital), civil defense, legislation, public relations and all our projects, the Florida report showed us doing more than our share.

The delegation from Florida included Mrs. Burns A. Dobbins Jr., Mrs. Francis D. Pierce and Mrs. George T. F. Rahilly from Broward County; Mrs. Sullivan G. Bedell and Mrs. John H. Mitchell from Duval County; Mrs. V. Marklin Johnson from Palm Beach County; Mrs. John M. Butcher from Sarasota County; Mrs. James N. Patterson from Hillsborough County; and Mrs. John R. Ramey, Mrs. R. Spencer Howell, Mrs. Edward F. Fox, Mrs. Frederick P. Poppe, Mrs. Donald F. Marion, Mrs. Randolph Shevach, Mrs. Paul S. Jarrett, Mrs. William C. Phillips, Mrs. Jack Q. Cleveland, Mrs. Milton M. Coplan and Mrs. Richard F. Stover from Dade County.

New officers of the Woman's Auxiliary to the American Medical Association elected on the last day of the convention are: Mrs. George Turner, Texas, president; Mrs. Mason G. Lawson, Arkansas, president-elect (Mona Lawson visited our Florida convention in 1952 and we all feel we know her well); Mrs. Robert Flanders, New Hampshire, first vice president; Mrs. Harlan English, Illinois, second vice president; Mrs. A. M. Okelberry, Utah, third vice president; Mrs. Clark Bailey, Kentucky, fourth vice president; Mrs. Thomas D'Angelo, New York, fifth vice president Mrs. George Garrison, Oklahoma, treasurer; and Mrs. Carl Burkland, California, constitutional secretary. Mrs. Richard F. Stover of Miami will again serve as Today's Health chairman for the national auxiliary.

The Florida heat followed us to California for the first two days of the convention, and San Francisco broke all records with an 89 on Monday, June 21. Then the Pacific breezes took over and all the Floridians enjoyed the cool air of the usual San Francisco weather once again. The convention next year will be held in Atlantic City and perhaps we can look forward to cool June days there next year.

Mrs. Richard F. Stover, President

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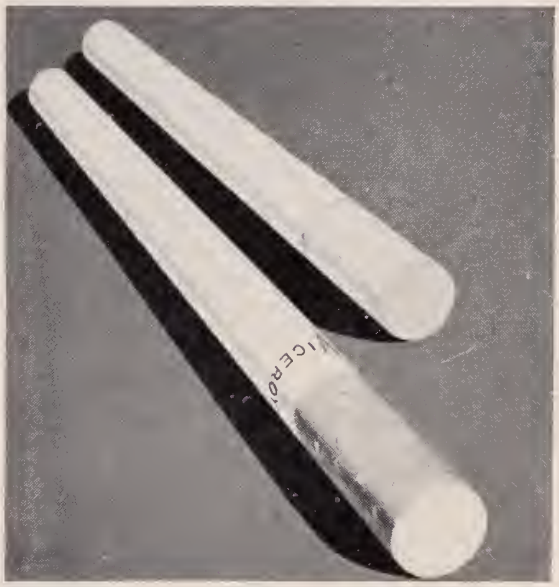


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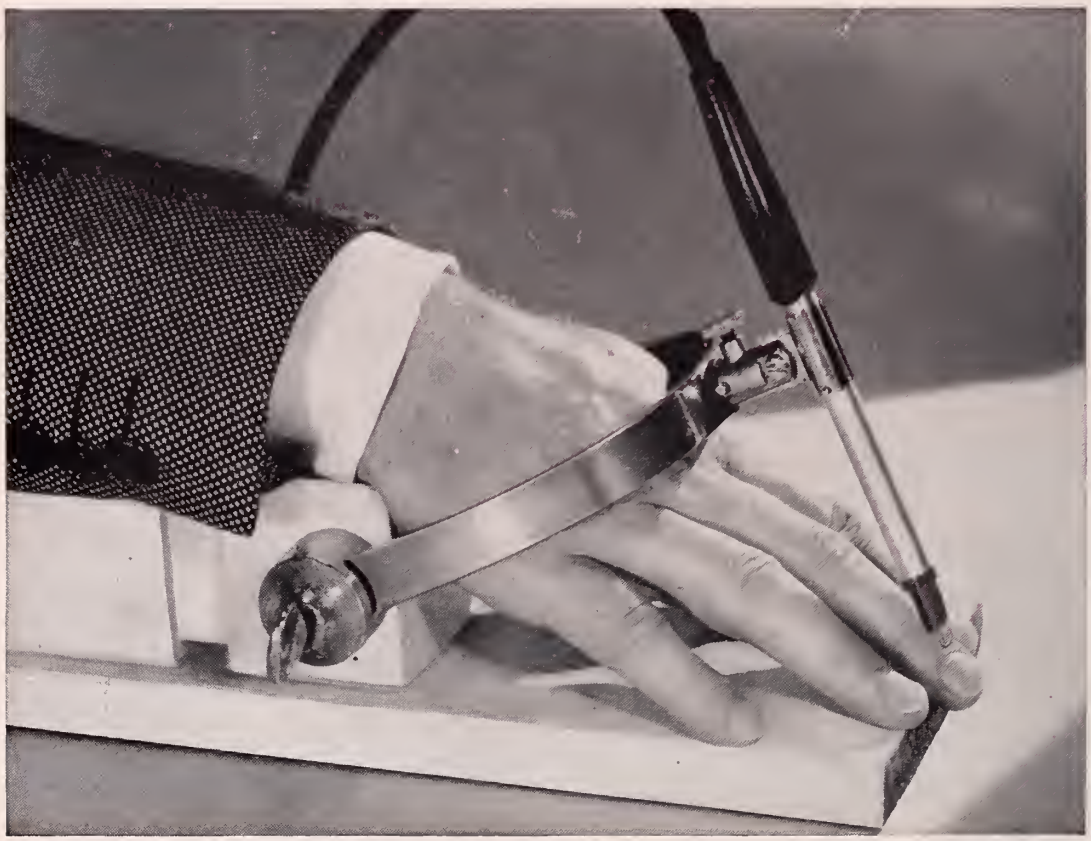
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Hialeah	1210 Pacific Bldg.	Tampa	228 Cass Street Arcade Building
St. Petersburg	509 White Building	Sarasota	1369 Main Street, Room 15
Lakeland	206 Marble Arcade	Daytona Beach	116½ Orange Avenue
West Palm Beach	305 Citizens Building	Pensacola	501 Theisen Building

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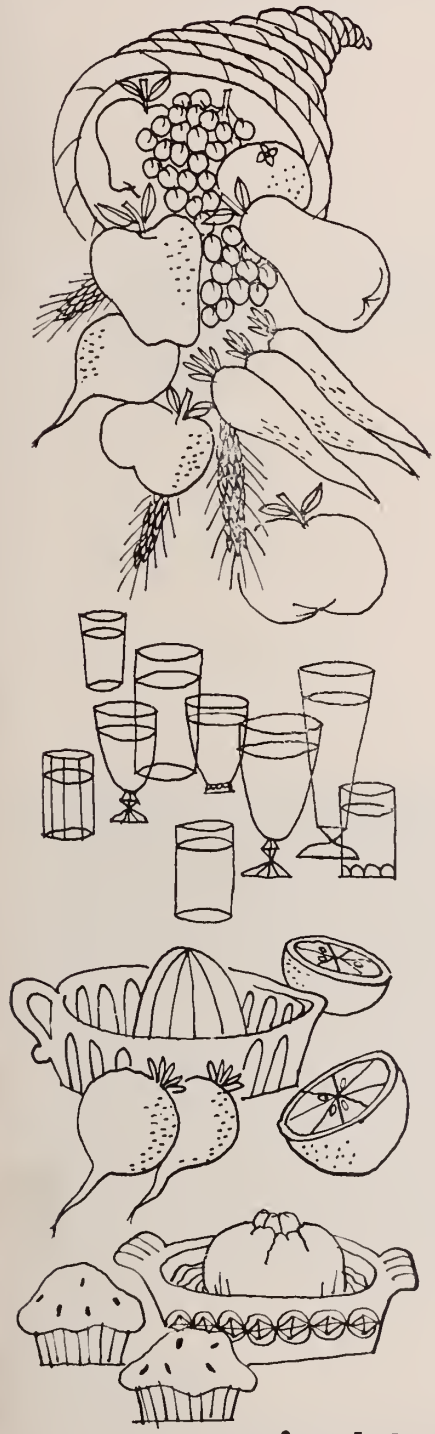
Thus KENT, with the first filter that really works, gives the one smoker out of every three who is susceptible to nicotine and tars the protection he needs . . . while offering the satisfaction he expects of fine tobacco.

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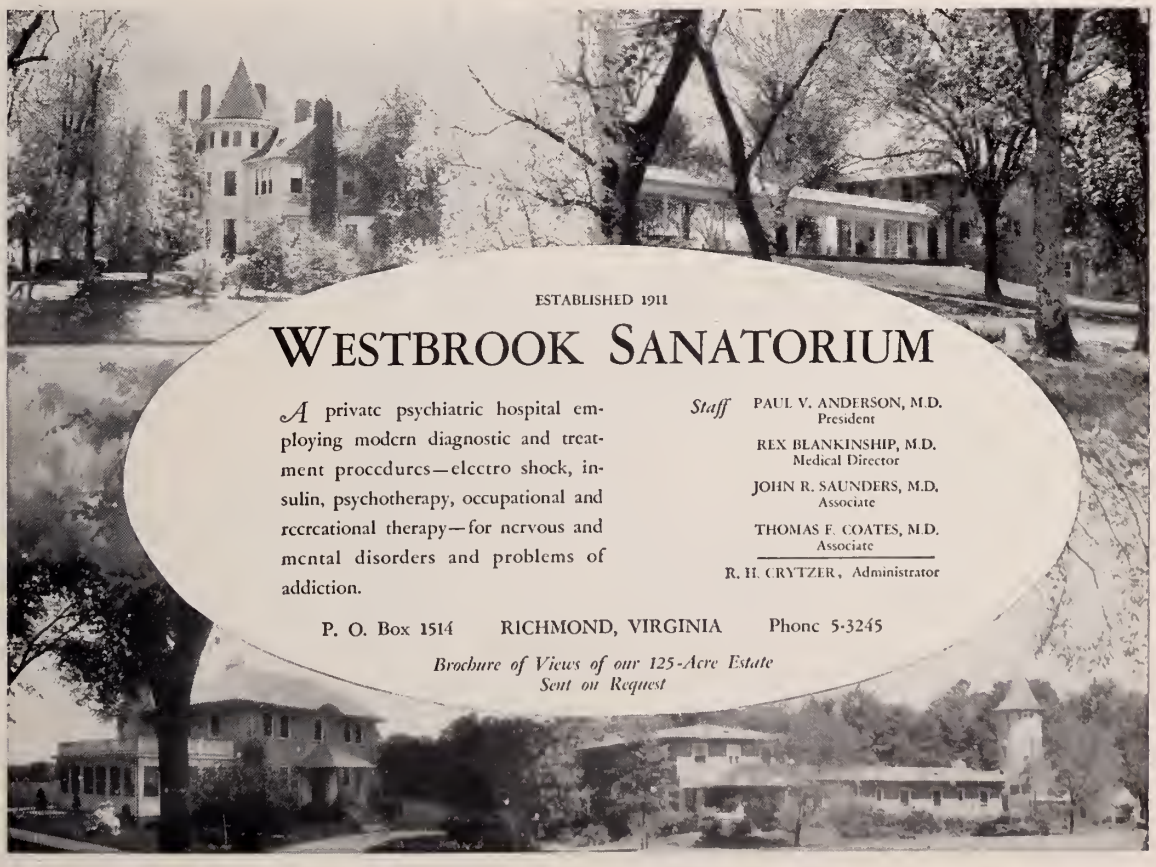
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
a Medical Association	Duncan T. McEwan, Orlando	Samuel M. Day, Jacksonville	St. Petersburg, Apr. 3-6, '55
a Medical Districts	Francis H. Langley, St. Petersburg	Council Chairman	
orthwest	William H. Hixon, Pensacola	George S. Palmer, Tallahassee	Marianna, Oct. 11, '54
ortheast	Henry J. Babers Jr., Gainesville	Thomas C. Kenaston, Cocoa	Sanford, Oct. 13, '54
outhwest	James R. Boulware Jr., Lakeland	Clyde O. Anderson, St. Petersburg	Sarasota, Oct. 15, '54
outheast	James R. Sory, West Palm Beach	Russell B. Carson, Ft. Lauderdale	Vero Beach, Oct. 14, '54
a Specialty Societies			
ay of General Practice	Leonard L. Weil, Miami Beach	Leon S. Eisenman, Hialeah	St. Petersburg, Apr. 3, '55
Society	Solomon D. Klotz, Orlando	Edwin P. Preston, Miami	" "
esiologists, Soc. of	R. Gaylord Lewis, West Palm Beach	Harry E. Bierley, West Palm Beach	" "
Phys., Am. Coll., Fla. Chap.	DeWitt C. Daughtry, Miami	Jack Reiss, Coral Gables	" "
and Syph., Soc. of			" "
Officers' Society	Thomas E. Morgan, Jacksonville	Lorenzo L. Parks, Jacksonville	" "
rial and Railway Surgeons	Plumer J. Manson, Miami	John H. Mitchell, Jacksonville	" "
ogy & Psychiatry	Sullivan G. Bedell, Jacksonville	Roger E. Phillips, Orlando	" "
l Gynec. Society	Harold G. Nix,Tampa	Reuben B. Chrisman Jr., Miami	" "
al. & Otol., Soc. of	G. Tayloe Gwathmey, Orlando	Carl S. McLemore, Orlando	" "
edic Society	John F. Lovejoy, Jacksonville	Newton C. McCollough, Orlando	" "
ogists, Society of	Millard B. White, Sarasota	James B. Leonard, Tampa	" "
ic Society	C. Jennings Derrick, W. Palm Bch.	Wesley S. Nock, Coral Gables	St. Petersburg Bch., Oct. 22-24, '54
logic Society	Claude G. Mentzer, Miami	George Williams Jr., Miami	St. Petersburg, Apr. 3, '55
ogical Society	A. Judson Graves, Jacksonville	James T. Shelden, Lakeland	" "
ns, Am. Coll., Fla. Chapter	Frederick J. Waas, Jacksonville	C. Frank Chunn, Tampa	" "
ical Society	Linus W. Hewit, Tampa	Frank J. Pyle, Orlando	" "
t—			
Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, Nov. 6, '54
d Banks, Association	John T. Stage, Jacksonville	John B. Ross, Jacksonville	St. Petersburg, 1955
Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	Palm Beach Shores, Nov. 17, '54
Shield of Florida, Inc.	David R. Murphey Jr., Tampa	Jack O. W. Rash, Miami	
er Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	St. Petersburg, Apr. 3, '55
cal Diabetes Assn.	Fred Mathers, Orlando	Edward R. Smith, Jacksonville	Orlando, Oct. 21-22, '54
al Society, State	Robt. Thoburn, D.D.S.,Daytona Bch	J. E. Edwards, D.D.S., Coral Gables	Jacksonville, Apr. 23-25, '55
t Association	Alvin E. Murphy, Palm Beach	Daniel R. Usdin, Jacksonville	April 1955
ital Association	Mr. J. F. Wymer Jr., W. Palm B.	Mrs. Mary Reeder, Miami	
ical Examining Board	Frank D. Gray, Orlando	Homer L. Pearson Jr., Miami	Jacksonville, Nov. 21-23, '54
ical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
e Anesthetists, Fla. Assn.	Miss Dorothy Jackson, C. Gables	Mrs. Lulla F. Bryan, Miami	Palm Bch. Shores, Nov. 17-19, '54
es Association, State	Mrs. Bertha King, Tampa	Mrs. Idalyn Lawthon, Tampa	November '54
maceutical Association, State	Mr. J. L. McDonald, St. Augustine	Mr. R. Q. Richards, Ft. Myers	Clearwater, May '55
ic Health Association	Frank M. Hall, Gainesville	Mr. Fred B. Ragland, Jacksonville	Miami Beach, Oct. '54
leau Society	Lawrence C. Manni, Tallahassee	Simon D. Doff, Jacksonville	May, 1955
rculosis & Health Assn.	Judge Ernest E. Mason, Pensacola	Mrs. L. C. Conant, Fort Myers	
an's Auxiliary	Mrs. Richard F. Stover, Miami	Mrs. S. J. Wilson, Ft. Lauderdale	St. Petersburg, Apr. 3, '55
an Medical Association	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	Atlantic City, June 6-10, '55
A. Clinical Session	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	Miami, Nov. 29-Dec. 2, '54
rn Medical Association	Alphonse McMahon, St. Louis	Mr. C. P. Loranz, Birmingham	St. Louis, Nov. 8-11, '54
na Medical Association	J. M. Donald, Birmingham	Douglas L. Cannon, Montgomery	Montgomery, Apr. 21-23, '55
a, Medical Assn. of	Peter B. Wright, Augusta	David Henry Poer, Atlanta	Augusta, May 1-4, '55
ospital Conference	Mr. John W. Gill, Vicksburg, Miss.	Mr. Pat Groner, Pensacola	Atlanta, Apr. 20-22, '55
astern Allergy Assn.	W. L. Rucks, Memphis, Tenn.	Kath. B. MacInnis, Columbia, S. C.	Orlando, 1955
astern, Am. Urological Assn.	Sam L. Raines, Memphis, Tenn.	Robert F. Sharp, New Orleans	New Orleans Mar. 20-23, '55
astern Surgical Congress	J. Duffy Hancock, Louisville, Ky.	B. T. Beasley, Atlanta	Atlanta, Mar. 7-10, '55
oast Clinical Society	Jas. N. Lockard, Pascagoula, Miss.	F. C. Minkler, Pascagoula, Miss.	Edgewater Park, Miss., Oct. 21-22, '54



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County Medical Societies of Florida

SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Total Members
Alachua	Henry H. Graham, Gainesville	Glenn O. Summerlin, Gainesville	2nd Tues.	51
***Bradford, Gilchrist, Union**				
Bay	Lemuel F. Coxe Jr., Panama City	James D. Nixon, Panama City	1st Tues.	26
Brevard	Theodore J. Kaminski, Melbourne	Paul L. Summers, Melbourne	2nd Tues.	28
Broward	Julius F. Boettner, Fort Lauderdale	George T. F. Rahilly, Fort Lauderdale	4th Tues.	108
Columbia	Robert B. Harkness, Lake City	Thomas H. Bates, Lake City	1st Mon.	12
***Baker, Hamilton**				
Dade	Edward W. Cullipher, Miami	Kenneth S. Whitmer, Miami	1st Tues.	669
DeSoto-Hardee-Highland-Glades	Carl J. Larsen, Avon Park	Samuel A. King, Avon Park	2nd Tues.	27
Duval	Karl B. Hanson, Jacksonville	Jackson L. Allgood Jr., Jacksonville	1st Tues.	272
***Clay**				
Escambia	Wilton E. Tugwell, Pensacola	Paul F. Baranco, Pensacola	2nd Tues.	97
***Santa Rosa**				
Franklin-Gulf	Albert L. Ward, Port St. Joe	Warren T. Weathington, Apalachicola	Last Wed.	9
Hillsborough	C. Frank Chunn, Tampa	Julien C. Pate Jr., Tampa	1st Tues.	179
Indian River	William L. Fitts 3rd, Vero Beach	Vernon L. Fromang, Vero Beach	2nd Tues.	10
Jackson-Calhoun	Jabe A. Breland, Marianna	Francis M. Watson, Marianna	Quarterly	18
Lake	J. Basil Hall, Tavares	James R. Hanson, Tavares	1st Wed.	28
***Sumter**				
Lee-Charlotte-Collier-Hendry	H. Quillian Jones, Fort Myers	James L. Bradley, Fort Myers	3rd Mon.	37
Leon-Gadsden-Liberty-Wakulla-Jefferson	George H. Massey, Quincy	Odis G. Kendrick Jr., Tallahassee	Quarterly	57
Madison	Wallace E. Winter, Madison	Julian M. DuRant, Madison		4
Manatee	Willett E. Wentzel, Bradenton	Marjorie L. Warner, Bradenton	2nd Tues.	25
Marion	William H. Anderson Jr., Ocala	Bertrand F. Drake, Dunnellon	3rd Tues.	30
***Levy**				
Monroe	Edward Gonzalez, Key West	Herman K. Moore, Key West	2nd Thurs.	12
Nassau	David G. Humphreys, Fernandina	John W. McClane, Fernandina	Last Fri.	11
Orange	Eugene L. Jewett, Orlando	Andrew W. Townes Jr., Orlando	3rd Wed.	184
***Osceola**				
Palm Beach	Thomas E. Daly, West Palm Beach	David A. Newman, Palm Beach	4th Mon.	133
Pasco-Hernando-Citrus	Frank Y. Robson, New Port Richey	W. Wardlaw Jones, Dade City	2nd Thurs.	18
Pinellas	Alvin L. Mills, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	218
Polk	Theodore C. Keramidas, Winter Haven	James T. Shelden, Lakeland	2nd Wed.	92
Putnam	Lawrence G. Hebel, Palatka	James A. Long Jr., Palatka	2nd Tues.	10
St. Johns	James J. DeVito, St. Augustine	Reuben J. Plant Jr., St. Augustine	3rd Tues.	19
St. Lucie-Okeechobee-Martin	Laurance D. Van Tilborg, Ft. Pierce	Adrian M. Sample, Fort Pierce	3rd Thurs.	21
Sarasota	Henry J. Vomacka, Sarasota	Lloyd J. Duest, Sarasota	2nd Tues.	53
Seminole	J. Clifford Boyce, Sanford	Terry Bird, Sanford	2nd Tues.	18
Suwannee	William P. Blackmon, Mayo	Hiram B. Curry, Jasper	1st Sat.	9
Taylor	George H. Warren, Perry	Walter J. Baker, Foley	Last Fri.	5
***Dixie, Lafayette**				
Volusia	Cleland D. Cochrane, Daytona Beach	Robert L. Miller, Daytona Beach	2nd Tues.	85
***Flagler**				
Walton-Okaloosa	Robert von P. Maxon, Fort Walton	Arthur G. Williams Jr., Valparaiso	3rd Thurs.	20
Washington-Holmes	Ralph H. Segrest, Bonifay	Bayllye W. Dalton, Chipley		6
				Total 2,601

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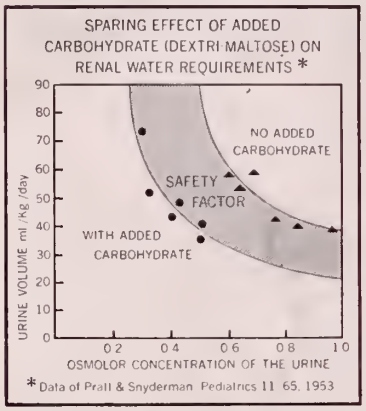
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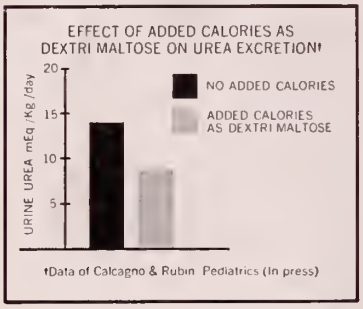
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1. Pratt & Snyderman: Pediatrics 11: 65, 1953; 2. Calcagno & Rubin: Pediatrics (in press); 3. Calcagno, Rubin & Weintraub: J. Clin. Investigation 33: 91, 1954; 4. Coake, Pratt & Darrow: Yale J. Biol. & Med. 22: 227, 1950; 5. Gamble: J. Pediat. 30: 488, 1947; 6. Rappaport: Am. J. Dis. Child. 74: 682, 1947.

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The Journal
OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XLI SEPTEMBER, 1954 No. 3

MEDICAL DISTRICT MEETINGS
OCTOBER 11 - 15, 1954

MEDICAL EDUCATION ISSUE

Medical Education and Patient Care
Wilburt C. Davison

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References
(1) Kirby, W. M. M.; Waddington, W. S., & Doornink, G. M.: Antibiotics Annual, 1953-1954, New York, Medical Encyclopedia, Inc., 1953, p. 285.
(2) Finland, M., & Haight, T. H.: *Arch. Int. Med.* **91**:143, 1953.



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1. Malleson, J.: Lancet 2:158 (July 25) 1953. 2. Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc. 1953, p. 23.

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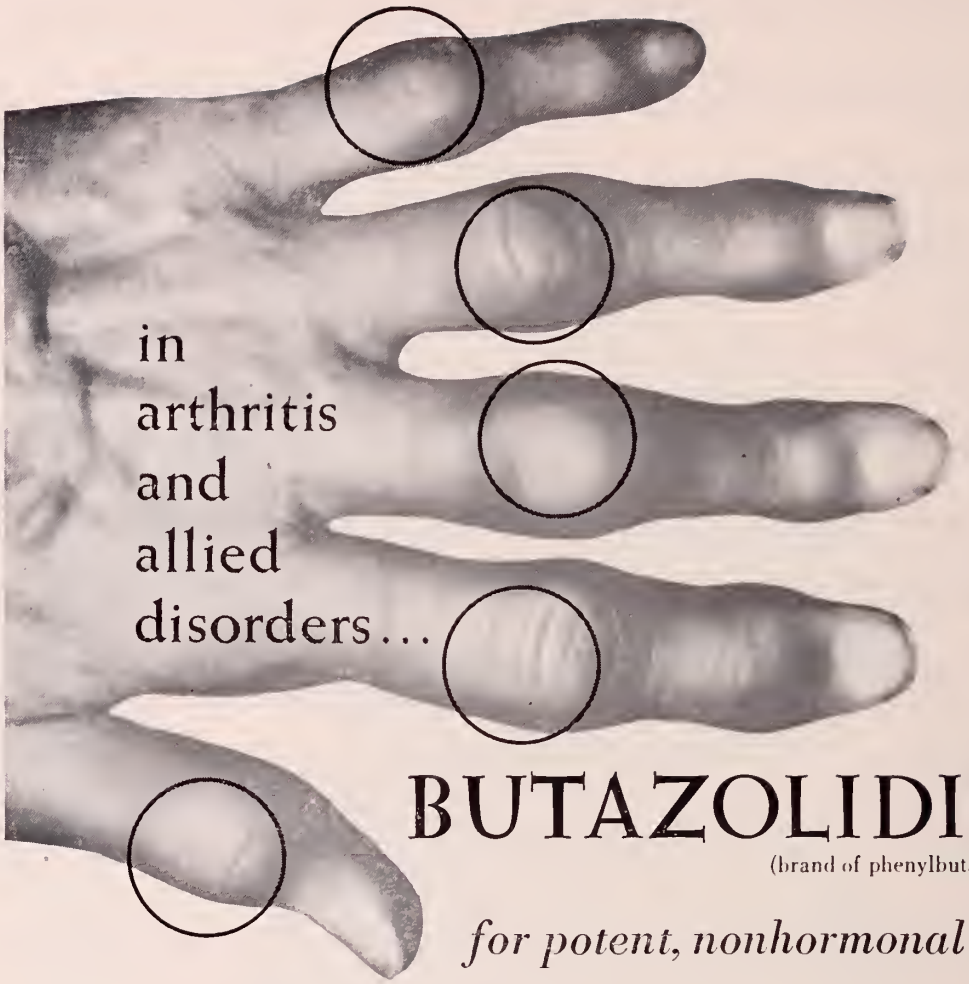
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Changes in Medical Education and Patient Care

WILBURT C. DAVISON, M.D.
DURHAM, N. C.

Money, both private and public, has been responsible in the past for the progressive changes which have occurred in American medical education and patient care. Now, unless more funds, both private and public, are obtained, and obtained quickly, this progress cannot be maintained. The previous advances can be divided into four epochs:

I. Lecture Mills

The proprietary, lecture mill or pre-Hopkins or pre-Harvard era began in 1765, when the first North American medical school was started by John Morgan (although the Faculdad de Medicina in Mexico was founded in 1578, and that of the Universitad de Lima, Peru, in 1638).[1] The first North American M.D. degree was granted by King's (now Columbia) College in 1770, and the first Ph.D. degree by Yale in 1861. This epoch ended in 1893, the entrance date of the first Johns Hopkins class.[2] In the eighteenth and for a greater part of the nineteenth century, except for the few Northerners who went to Scotland on their own initiative for a medical education, and the Southerners who were sent to France by wealthy planters in order to give their slaves good medical care,[3] most of the American doctors received their training by apprenticeships. Physicians soon found, however, that it was financially profitable, from the students' fees, as well as from the income from the increased practice attracted by a medical school professor, to organize commercial proprietary medical schools, and by 1893, 160 of them had sprung up in various parts of the country. Some of them had nominal connections with universities, as at Pennsylvania, Harvard, Virginia, Transylvania and Florida,[4] but in general they were organized to make money for the faculty, and with little or no thought given to medical education. Courses at most of these lecture mills were limited to two sessions of three or four months each, there was no division into grades, and the pupils sat through the same curriculum twice over, on the theory that what they had missed the first time they might understand the second.[5] Hospital and laboratory work was almost unknown.[4] It is true that "there were giants in the earth in those days,"[6] such as Cabell, Drake, Holmes, Howland, Long, Matas, McDowell, Nott, Osler, Reed, Sims, and Welch,[7] but there were far too many Lilliputians, and the United States was ripe for the next era.

II. Ward Teaching

The transition, ward or pre-Flexner epoch lasted from 1893 to 1910 when the Flexner report to the American Medical Association[8] purged the proprietary schools. This era, like its proprietary predecessor, was based on money, though from a different point of view. Johns Hopkins' will in 1878 provided $7,000,000 to build and endow a university, hospital and medical school, an enormous sum for those days before inflation. The trustees and John Shaw Billings studied and prof-

From the Department of Pediatrics, Duke University School of Medicine and Duke Hospital, Durham, N. C.; with the assistance of Dr. Alan M. Chesney, The Johns Hopkins University School of Medicine, Miss Judith Farrar, Assistant Professor of Medical Literature, Duke University School of Medicine, and Mrs. Anne Tipner, Secretary to the Secretary of the Council on Medical Education and Hospitals of the American Medical Association, to whom great thanks are due.

Presented May 28, 1952, at the Raleigh Academy of Medicine, Raleigh, N. C.; Sept. 26, 1952, at the Naval Medical School, National Naval Medical Center, Bethesda, Md.; Nov. 18, 1952, at the Army Medical Service School, Brooke Army Medical Center, Fort Sam Houston, Texas, and April 27, 1954, at the Eightieth Annual Meeting of the Florida Medical Association, Hollywood, Fla.

ited from the renaissance of university medical education in Germany, which had been financed by the indemnity collected from the French after the Franco-Prussian War (again money),[9] and opened the first "modern" American hospital and medical school in 1889 and 1893 respectively.[10] The Hopkins contribution in 1893 was fivefold: (1) assembling an outstanding faculty of four young men, consisting of Osler, Welch, Halsted and Kelly (their average age was 35 years); (2) the requirement of a college degree for admission; (3) the first four-year medical curriculum; (4) the introduction of students into the wards and laboratories (Osler "desired no other epitaph, than the statement that I taught medical students in the wards");[2] and (5) last but probably more important than any other factor responsible for the elevation of medical education, the rigid selection of students. The selection of medical students with emphasis on character, as well as preparation, is, or should be, one of the most important tasks of a medical faculty. A good student will become a good physician regardless of the instruction he receives, while a mediocre one rarely does.[11]

Up to 1893, any untrained lad was allowed to study medicine anywhere in America, and although John Morgan in 1765[12] and Daniel Drake in 1820 had recommended a broad premedical education, these entrance requirements were thrown into the dump heap whence they were salvaged with great éclat by the founders of the Johns Hopkins University.[5]

For the first few years, the Hopkins faculty wondered whether the baccalaureate entrance requirement and the four-year curriculum would deter students from applying; in fact, most of the original faculty admitted that they themselves could not have fulfilled the admission requirements.[2] The classes, however, were soon filled, and other university schools, including Harvard,[13] followed this pattern.

During this era, efforts were made to design the medical schools and hospitals so that the diseases and the normal and abnormal functions of the patients could be studied and taught in the wards and laboratories. The curricula were revamped and lengthened, and the entrance requirements raised so that the last high school student to enter directly into medical school did so in 1910. Most of the schools soon required one to three years of premedical college work for admission, and a few of them, like the Hopkins and Cornell insisted on a degree. By 1908, there were three classes of medical schools, good, bad and indifferent, and the Council on Medical Education of the American Medical Association, with funds from the Carnegie Foundation and with the cooperation of the Association of American Medical Colleges, authorized Nathan P. Colwell and Abraham Flexner to inspect all of the schools. The Flexner report[8] classified 148 of the 160 schools as A, B and C, and the State Boards of Medical Licensure, which had arisen in the 1880's and 1890's, were asked to license only the graduates of the 66 Class A schools. By 1910 when the report was published, the total number of schools had dropped to 95.

Nursing education is in this transition stage at present, but is awaiting a modern Florence Nightingale to follow Osler's example, namely, to lead the nurses back from the lecture halls to the patients. The best care of the patient is the best training for students of nursing, as well as for those in medicine.[14] Nursing and medical teachers should follow paths which converge on the patient, instead of diverging, both in nursing and medical education, to the classroom and laboratory.[15]

III. Laboratory Emphasis

The scientific or laboratory era spanned the four decades from 1910 to 1950, the age of "wonder and miracle drugs."[16] Again, money had produced changes in medical education and patient care. During this period, the munificent gifts of the Rockefeller Foundation with Abraham Flexner, Richard M. Pearce Jr., and Alan Gregg as Directors, the Carnegie Foundation, Commonwealth Fund, George Eastman, James B. Duke, John and Mary R. Markle Foundation, National Institutes of Health of the United States Public Health Service of the Department of Health, Education and Welfare, National Foundation for Infantile Paralysis, National Tuberculosis Association, American Cancer Society, American Heart Society, Army, Navy, Air Force, and Veterans Administration, to mention only a few sources of funds, enabled the Hopkins, Washington, Iowa, Rochester, Vanderbilt, Harvard, Duke and other universities to establish "strictly" full-time or "geographic" full-time departments.[17] Appropriations to state-supported schools also were greatly increased. This era has been called the golden epoch in American Medicine.[18]

Although similar progress was made in other medical fields, pediatrics is an excellent illustration of these changes. For example, John Howland at the Hopkins in 1912 to 1926 established pediatrics on a university full-time level, and his 30 disciples became heads of pediatric departments in medical schools in the United States, England, Hungary and Japan.[19] Pediatrics became simplified,[20] and preventive measures soon shifted the emphasis from the need of caring for sick children to the more important problem of keeping them in sound physical and mental health.[21]

During the flowering of this scientific era, the medical school curricula expanded into biochemistry, mycology, virology, enzymology, vitamins, nutrition and chemotherapy (two thirds of the drugs now used were unknown 10 years ago).[22] The introduction of these "wonder and miracle drugs"[16] has led to the administration of sulfonamides, penicillin, streptomycin, Aureomycin, Terramycin, ACTH, cortisone, Chloromycetin, and others, for several days (sometimes together, but usually in succession) without examining the patient, and then trying to diagnose when the treatment is unsuccessful. Instructors should realize that, regardless of arguments to the contrary, this practice will be continued as it usually is effective and rarely does harm. What is the use of clinics on pneumonia if patients are cured before the physical and roentgenologic signs can be demonstrated? Though appalling from the point of view of the teaching of medicine, this trend has simplified its practice and has led to the end of the "scientific era."

IV. Ambulatory Patient Care

The humanitarian or outpatient or ambulatory patient epoch started about 1950 with an effort to focus the attention of medical students and the profession on the patient, not solely as the site of a disease but as a human being and as a member of his family and community with many other problems in addition to his illness, which require advice and adjustment.[23,24] This new concept is a symptom of the growing discontent with medical education and the numerous attempts to improve it, which are the greatest assets of American medical education, and are in marked contrast to the German self satisfaction.[25] American and German medical education were on a par after the Flexner purge of 1910-1915,[8] but Americans have gone ahead while the Germans not only failed to keep pace with modern medicine, but have slid backwards. Their situation should be a constant reminder to us not to let our pride in our achievements prevent us from trying to climb higher.[26] Fortunately, the Commonwealth Fund has financed a curriculum study at Western Reserve Medical School, and other experiments are under way at some of the other schools.

During this past generation from 1910 to 1950, diseases were studied and methods to prevent and cure some of them were found, but the patient as a whole was often disregarded. The focus now should be on rediscovering the patient, his nature and behavior as an individual. The greatest need of the present era is for a professor of ambulant medicine who can correlate the patient's clinic and hospital diagnosis and treatment with his total care, and thus maintain his physical and mental health. More instruction is needed in medicine, pediatrics and psychiatry, and less in anatomy and surgery. The medical schools no longer train "physicians and surgeons;" so surgery should be a postgraduate subject. Yet in some medical schools, 25 per cent of the available hours are still assigned to anatomy and another 25 per cent to surgery and the surgical specialties.

The present day approach to medical education must be based upon a new concept of preventive medicine, an awareness of the role of the doctor in society, the realization of the true nature of the patient-physician relationship and the necessity for continuity and integration in patient care. The physician must be prepared to assume the leadership in the community in health matters and to furnish expert and unselfish advice in order to aid in the solution of these problems. This concept that the physician is responsible for the health of his patients, rather than only for their illnesses, calls for an active indoctrination of the student into a "comprehensive" type of medicine which evaluates the social and emotional components as they bear upon health and disease. Provision must be made in the medical schools to allow the students to learn and *practice* total continuity of patient care, through participation in medical care in the home,[23, 24, 27, 28] or by preceptorships with qualified general practitioners. The latter type of training has been offered at Duke since its opening in 1930.[29] F. W. S. Brimblecombe's scheme for the Home

Care of Sick Children by the staff of St. Mary's Hospital, London, will do for the masses what is occasionally done only for the privileged few. It would be of great psychologic benefit to the patients as well as a financial saving to their families and the hospital. Many educators forget that a similar program was started in Boston in 1875,[27] and was used by Osler at the Johns Hopkins in 1895, as well as at Syracuse, Georgia and other medical schools,[28] and that some of this training was formerly provided by the now abandoned "outside obstetrics." The faculties of the medical schools must be expanded in order to include in the everyday work-up of patients by the students, the concepts which can be furnished by psychodynamically oriented psychiatrists, highly qualified social workers, psychologists, sociologists, biometricians, statisticians, and others.[30]

This transition from teaching disease in hospital wards to the total care of ambulatory patients has been hastened, if not made necessary, by the almost universal and usually successful sulfonamide and antibiotic ambulant therapy, as well as by preventive measures, which have greatly reduced the frequency of many hospital conditions, which were common in 1930,[31] so that now the outpatient clinic has become, by far, the more important teaching service.[21] Eventually, hospitals should be empty, except for neonates, prematures, the ill children of working mothers, accident patients, those subjected to unpreventable surgical operations, obstetric patients and those presenting difficult medical, pediatric and psychiatric problems. More space, a larger percentage of the teaching hours, and the best instructors are needed for the outpatient instruction of medical and nursing students. Each member of the senior staff should work in the outpatient clinic at least one afternoon per week in order to know the students on a less formal basis. Furthermore, the senior faculty by working in the outpatient clinic, can rediscover with the students the humanitarian approach to medicine. The preceptorial program in which senior students spend two weeks with a philosophic practitioner of medicine has helped to fill this need.[29]

Keeping patients out of hospitals and treating them in a physician's office or outpatient clinic not only is a great psychologic benefit, but the financial saving is enormous, regardless of whether the patients, parents, taxpayers or university endowments pay the bill. For example, the actual daily cost of a Duke Hospital bed is $19.57, while the average office or outpatient visit charge is $5. Most patients cannot afford hospital costs, but they usually can pay physicians' or clinic fees.

During and after the second war, medicine learned teamwork with the paramedical group, the doctor acting as captain but only as one member of the team in providing patient care. For every 27 hours of care received by the average patient, only one hour (3.7 per cent) is performed by physicians, a large portion being given, and most efficiently given, by nurses, social workers, technicians, psychologists, sociologists, and others.[32, 33] The field of preventive psychiatry and psychosomatic medicine requires that physicians and ancillary groups must work together, and the ideal place is in the outpatient clinic or physician's office.

This new concept of medical education is a complete reversal of Osler's emphasis on ward teaching[2] and of Francis W. Peabody's statement that the general ward was the backbone of the clinic.[34] The new buildings at Michigan, Duke and some other schools indicate the belief that the outpatient clinic is not only the backbone but also the soul of the clinic. By analogy to automobiles, this new goal is the operation of a service station to keep the patient well and happy, rather than to run a repair shop.

Medical Progress

Medical progress can be continued and its humanitarian goals attained if the schools and profession will face and solve the 10 problems listed. The greatest present obstacle to their solution is the need for money for faculty salaries, operating expenses, increased working space and other facilities. The higher financial rewards of private practice and of commercial laboratories are largely responsible for the difficulty in recruiting personnel for the medical school faculties, as well as for the Army, Navy, Air Force, Veterans Administration and Atomic Energy Commission.

1. — CURRICULUM: In spite of the protests of students and teachers, the *accelerated schedule* has demonstrated its value. It is right in principle and advantageous in practice. Seventy-six per cent of the Duke students are graduated in less than four calendar years on the voluntary accelerated program, which is now in its twenty-

fourth year.[17] A year can be saved by condensing the four medical school years of 33 weeks into three years of 44 weeks each. The advantages to the medical student are obvious. He will be one year younger at graduation and will have an additional year for hospital or other training; he will be better prepared, for he will not have lost a fortnight or a month in October of each year getting back into the intellectual stride which had been his in the preceding June, and he will see the clinical material peculiar to the summer months.[35, 36] In addition to these benefits to the students, the utilization of the buildings and laboratories for a full calendar year instead of the usual academic eight months will enable the schools to admit one third more students if funds can be obtained to employ as medical teachers the hundreds of young graduates who at present are working on outside research grants.

2. — Premedical Education: There is also need for overhauling premedical education.[37] The time has come when the medical schools should consider the inclusion of premedical courses in their curricula similarly to the Canadian, British, Danish and Swedish programs.[38] Ours is the only country in which the medical schools do not supervise premedical education.[26] The universities and medical schools should have a cooperative program[39, 40] to which the students would be admitted directly from high school to study English, mathematics, chemistry, physics, and biology and social studies for the first two years with advancement to the medical courses at the end of their sophomore year only if they give promise of being a credit to themselves and their universities. In this way, one or two years of the present three to four years premedical preparation could be saved, and its quality would be better than is usually furnished by many of the colleges and universities, whose instructors tend to cram masses of facts and information into students without much emphasis on their understanding the subject itself or on the application or the integration of the material. Factual content assumes a position of paramount importance to the exclusion of knowledge, wisdom or philosophy. It is far more important for a student to have a clear idea of the subject than it is to be befuddled by too much information about it. More emphasis should be placed on the significance and meaning of data rather than on their accumulation.[41]

It has often appeared to the Duke faculty that some of the difficulties and resistances which have been encountered in teaching psychiatry and comprehensive medicine to medical students might in part be due to their lack of training in or understanding of the evolution of society and of medicine's place in it. As far as can be ascertained, orientation in these matters is nonexistent in the colleges. Would it not prove profitable to study the relationship of medicine to society (past and present), to correlate existing information on the subject and so to furnish material which might be used in sociology courses for premedical students in colleges? In this type of course, the student might obtain a clearer understanding of his role as a physician.[30]

Another variation of this integrated premedical and medical program is the selection of top-flight premedical students at the end of their freshman year, as suggested by Conant,[40] and guaranteeing them admission at the end of their sophomore or junior year on the sole condition that they complete the entrance requirements and maintain the qualifications which led to their original selection. Duke is following this plan as a limited experiment to enable premedical students accepted at the end of their sophomore year to obtain a good education rather than the usual collection of semester hours which are now necessary in order to meet the various and bizarre entrance requirements of the several medical schools to which most students apply in their last year of college. If it is successful, the plan will be expanded. It is realized that this program may be criticized for accepting students before they have been properly appraised. The same charge, however, was made against the Johns Hopkins when that school admitted students 12 months before the medical class started, instead of three months as all schools practiced until 1925.[11] Now every school admits its candidates six to 12 months before the medical class starts.

3. — Financing of Medical Students: Probably the best way by which a sufficient number of students can attend medical school is through interest-bearing loan funds, which can be repaid over a period of years, and thus become available for future students. The usual scholarships require too great an outlay.[12] Loan funds to students who have agreed to practice in the country or to intern in rural hospitals have been helpful.[13] The proposed Army, Navy, Air Force

and Public Health scholarships for medical students who plan careers in these services are mutually advantageous. Physicians entering the federal services should be financed similarly to West Point and Annapolis line officers.

4. — MEETING THE MOUNTING COST OF MEDICAL EDUCATION: The approach probably should be to request the communities for reimbursement of the medical schools for their professional services to indigent patients.[14] The state and counties in North Carolina and some other states have now accepted responsibility for paying for hospital care and have saved Duke University an annual average of a quarter of a million dollars. If the state and counties would also contribute only one dollar per outpatient visit and a dollar per day for the professional care of the public ward (not private) patients, they would relieve the pressure on the Duke Medical School annual budget by an additional $250,000. Hospital costs, patients' bills, and medical school subsidies also can be reduced by not admitting any patient who can and should be treated in the outpatient service.[15] The money raised by medical alumni, the American Medical Education Foundation, the National Fund for Medical Education, and payments to Duke by Florida also are of inestimable help.

5. — FINANCING THE PATIENT: Experimentation in the distribution of medical service has been taking place for many years throughout the United States, starting in Virginia in 1773, with the provision of institutions for the insane, followed in 1798 and 1820, respectively, by the Marine and Naval Hospitals for sailors. The former was supported by taxes and the latter by a wage deduction like modern Blue Cross Hospital Associations. The problem now is how rapidly the proportion between public-supported and private medicine should be changed. The Blue Cross and the Blue Shield Associations for those who are self-supporting, and county, state and federal funds for the indigent seem to be the logical answer. The danger is great that if the federal or state governments take over medical practice, they will not provide good medical care but only cheap service.[16] Our greatest need is for a prepayment plan to provide ambulant office and clinic diagnostic and laboratory service.

6. — THE "DEMAND" FOR MORE PHYSICIANS: Especially in general practice and particularly in rural areas, the "demand" for more physicians is acute,[17] in spite of statements that the public does not *"need"* them.[18] Technically, the opponents of more graduates may be correct in saying that the public and federal services do not need more physicians. It depends on one's definition of need. Joe Doake may not *need* a new automobile whenever he buys one, but he would resent anyone denying him one if he *demanded* it and could pay for it. The public as well as the federal services feel the same way about more physicians and wider medical service, and should have it if they are willing through personal, foundation, state and federal funds to finance the expansion of the medical schools. Statistics showing that the United States has more physicians per population than most other countries and that our medical care is the best in the world[18] do not convince Joe Doake, either as a civilian patient, farmer, union worker or wounded soldier, when he wants a doctor in a hurry. As a matter of fact, these or any statistics, as everyone knows, are misleading.[18] From 1940 to 1950, the growth of the population and that of the medical profession were the same (15 per cent); so their 1940 and 1950 ratios are identical. The federal services, industry, and other groups, however, have absorbed so many physicians that the actual increase of those in practice was only 5 per cent, thereby creating a deficit of 10 per cent in the ratio of practicing physicians to the population. Even worse is the situation in regard to general practitioners, for their numbers have decreased 13 per cent from 1940 to 1950 in contrast to the 15 per cent increase in population, leaving the public with a net decrease of 28 per cent in available family doctors.[36] Furthermore, the increasing age of the remaining general practitioners has greatly intensified the need* for more recruits in this field.[19]

In spite of the program to educate the public that better medical care, especially for the seriously ill, can be provided by transporting the patients to a hospital or clinic, and that this trip gives them not only the advantage of modern facilities for diagnosis and treatment but also medical service in a shorter time than usually is required to summon a local physician, all of which is true, many patients still prefer having their pulses taken at the bedside at home. The existence of these public beliefs, and of an increas-

*Of the 435 recent community requests to Duke for physicians, the majority were for general practitioners, a few for pediatricians, internists and otolaryngologists, but none for general surgeons.

ing *"demand"* for more medical services must be recognized and met.[50] Giving the public more physicians and a wider distribution of medical service is the surest way of avoiding state medicine.[46, 50]

7. — Overspecialization: Starting after the first war and fostered by the GI Bill of Rights of the second war, overspecialization has now become a menace to the wider distribution of medical service and a potent deterrent to graduates from entering general practice.[51] The prestige of the specialty boards, and the increased rank and pay by the governmental services and the limitation of hospital privileges to board-certified physicians have been too alluring. These boards were started in order to protect the public against unwarranted claims by ill-qualified specialists, but like the monster built by Frankenstein, or the tail that wagged the dog, the specialty boards are now dominating medical practice and are even trying to dictate to the medical schools the subjects to be included in the curriculum and the emphasis thereon. Each year, it is hoped that the specialty fields will be saturated, and only in the past year has there been such slackening.

8. — General Practice: The question, "Is the general practitioner doomed or is the profession overspecialized?" is easily answered. A well trained general practitioner can and does treat successfully 85 per cent of disease, and as his volume enables him to treat his patients at a lower cost, the public needs and wants more general practitioners. The fact that only 25 to 40 per cent of the present American medical graduates are or plan to be general practitioners, who are needed by 85 per cent of the patients, not only means that the specialities may soon be overcrowded (though that may be wishful thinking), but also indicates the urgent need and wide open opportunities for family physicians.[49, 52, 53] Furthermore, this plethora of specialists has caused such competition and crowding that in many communities the financial rewards of general practitioners, with their reduced competition, are higher than those of specialists. The American Academy of General Practice is helping to recruit prospective general practitioners and has raised their morale and increased their privileges and dignity. Demonstrating the advantages of general practice in groups, rather than group practice, may help recruitment.[53]

The medical schools and teaching hospitals, as well as the specialty boards, also are responsible for this drift away from general practice by too much emphasis on medical rarities and "straight" internships. More teaching on the common conditions and problems in the outpatient service, and better rotating internships of one or two years' duration with emphasis on medicine, psychiatry and pediatrics are needed. Experience has shown that if rotating and straight internships are given in the same hospital, the former are neglected, discouraged and sabotaged by the teaching and resident staff. The recent recommendation by the American Medical Association that straight internships should be restricted has been helpful in orienting medical students and staff to the importance of having all graduates take rotating internships before embarking on a specialty residency. Whatever the cause, the percentage of medical students who are applying for rotating internships and who are seriously considering general practice has markedly increased.

9. — Country Doctors: Surveys showed that 83 per cent of the Tennessee and 58 per cent of the Minnesota rural medical students returned to country practice and that only 20 and 22 per cent, respectively, of the city students settled in rural communities.[54] More country medical students, therefore, mean more rural practitioners. Unfortunately, there are entirely too few rural medical students. A recent national analysis of 6,011 first-year medical students revealed that only 12 listed an address on a rural route,[55] yet nearly half of our population is rural.[49] There are at least three reasons for this dearth of country medical students: (1) *Finances:* Because a city student has more sources for borrowing, several states have established loan funds and scholarships for students who agree to practice in the country.[43] (2) *Inadequate Country High Schools:* Usually country high schools do not provide an adequate foundation for college premedical courses so that a rural youth can compete successfully for admission to medical school with the students from the private preparatory schools or the better city high schools.[56] The fact that the percentage of rural medical students at Duke has risen from 4 in 1940 to 20 in 1953[57] is an indication that the country high schools have improved. Funds are now being sought, so far

unsuccessfully, to provide a tutoring program at Duke during the summer vacations in order to give carefully selected rural high school students, who wish to study medicine, a more adequate preparation for premedical college work.[56] (3) *Hospital Availability:* Another weighty factor in attracting recent graduates to practice is the availability of hospitals. The young, highly trained physician of today does not feel that he can practice modern medicine without access to a hospital. The hospitals in North and South Carolina assisted by the Duke Endowment, and those built under the Hill-Burton Act, have filled this need.

10. — RESEARCH: In some schools, the large research grants instead of aiding medical education have had the opposite effect.[58] Obviously, research is necessary for good medical education in order to stimulate the staff and students[26] and to make the patients feel that the latest discoveries are available to them, as well as to advance medicine, but equally obviously there is a point at which the research is of more value to medicine in general and to society than to medical education.[14] One of the causes for the decline of prewar German medical education was the overemphasis on research, and the siphoning of the best brains away from the medical schools, and segregating them into the Kaiser Wilhelm Institutes.[25] The present huge research grants may convert some of the American medical schools into similar research institutes. The dangers of overbalanced research in medical schools should be emphasized, and faculties should remember that: (1) the primary reason for a medical school is the instruction of undergraduate and graduate medical students at the highest level of standards,[13] (2) instructors should be selected on the basis of their teaching ability rather than on their prolific writing,[59] (3) research is essential to sound medical education, (4) too much research by medical school faculties may kill the goose which laid the golden eggs (assuming, of course, that well taught physicians are golden eggs), and (5) the pressure to produce papers will reduce the quality of research and give the investigator an erroneous idea of the relative value and balance of research and teaching. Medical schools need more first-rate clinicians like Osler and Peabody, who are oriented to this new concept of ambulatory medicine, instead of the present plethora of young Pasteurs.[15]

Summary

North American medical education can be divided into four eras or periods: lecture mills (1765-1893), ward teaching (1893-1910), laboratory emphasis (1910-1950), and outpatient or ambulatory patient care (1950-).

During the present epoch, the attention of students and faculty is or should be focused on the patient, not solely as the site of a disease, but as a human being and as a member of his family and community with many other problems in addition to his illness which require advice and adjustment.

More outpatient teaching, home visits and preceptorial experience with general practitioners are needed to make the students and staff cognizant of the family, community and environmental relationships of medicine.

Premedical and medical education should be integrated and an accelerated curriculum used.

More loan funds are needed for medical students.

In order to maintain the present standards, more money is needed for medical faculty salaries, operating expenses, increased working space and other facilities.

States and counties should reimburse the medical schools for their professional care of indigent patients.

State and federal funds should adequately finance the expansion of medical schools to meet the demand for more physicians, especially for rural general practitioners.

Research is a necessity for sound medical education, but should be coordinated with teaching and not submerge it, and instructors should be appointed on the basis of their teaching ability rather than solely on their prolific writing.

References

1. Fulton J. F.: History of Medical Education, Brit. M. J. 2:457-461 (Aug. 29) 1953; Davison, W. C.: Thumbnail Sketches of Eminent Physicians; John Morgan (1735-1789) Founder of First American Medical School, North Carolina M. J. 5:434 (Sept.) 1944.
2. Davison, W. C.: Sir William Osler; Reminiscences, McGill M. J. 16:157-182 (April) 1947; also, North Carolina M. J. 10:136-138 (March) 1949; also, Arch. Int. Med. 84:110-128 (July) 1949; idem: Osler's Influence, J. A. Am. M. Coll. 25:161-173 (May) 1950.
3. Shryock, R. H.: Selections from Letters of Richard D. Arnold; Medical Series; 1834-1875, Bull. John Hopkins Hosp. 42:156-184 (March) 1928; 213-239 (April) 1928.
4. Davison, W. C.: Southern Medical Schools and Physicians of Past Century and a Half, J. A. Am. M. Coll. 15:123-128 (March) 1940; idem: James Lawrence Cabell (1813-1889), Bull. Johns Hopkins Hosp. 49:328-329 (Nov.) 1931.
5. Flexner, J. T. : Doctors on Horseback; Pioneers of American Medicine, New York, Viking Press, Inc., 1937.
6. Genesis 6:4 (Bible); Taylor, F. R.: There Were Giants in Those Days; Evolution of Medicine, North Carolina M. J. 13:479-485 (Sept.) 1952.
7. Davison, W. C., and Forbus, W. D.: Fourteen Distinguished Physicians and Surgeons — Brief Sketches of Eminent Men for Whom the Duke Hospital Wards Are Named, Dedication of Duke University School of Medicine and Duke Hospital (April 20) 1931.

8. Flexner, A.: Medical Education in the United States and Canada, Bull. No. 4, New York, Carnegie Foundation, 1910.
9. Hall, G. S.: Life and Confessions of a Psychologist, New York, D. Appleton & Co., 1924.
10. Billings, J. S.: Description of The Johns Hopkins Hospital, Baltimore, Friedenwald, 1890; Chesney, A. M.: The Johns Hopkins Hospital and The Johns Hopkins University School of Medicine; A Chronicle. Volume I: Early Years, 1861-1893, Baltimore, Johns Hopkins Press, 1943; Shryock, R. H.: The Unique Influence of the Johns Hopkins University on American Medicine, Copenhagen, Ejner Munksgaard, 1953.
11. Davison, W. C.: Selection of Medical Students, South. M. J. 20:955-960 (Dec.) 1927; idem: Qualities Which Medical Student and Physician Should Have or Develop, J. A. Am. M. Coll. 16:278-281 (Sept.) 1941.
12. Morgan, J.: A Discourse Upon the Institution of Medical Schools in America, Reprinted from the First Edition, Philadelphia, 1765. Publications of the Institute of the History of Medicine, The Johns Hopkins University, Fourth Series. Bibliotheca Medica Americana. Vol. II. Baltimore, Johns Hopkins Press, 1937.
13. Rappleye, W. C.: The Struggle to Maintain Standards, Pharos. 17: 3-7, 20 (Nov.) 1952.
14. Davison, W. C.: Nursing as Foundation of Medicine, North Carolina M. J. 4:141-143 (April) 1943.
15. Davison, W. C.: Let's Give the Medical Schools Back to the Students, Allow the Faculty to Teach, and Obtain Adequate Operating Funds so That Balanced Research in Medical Schools May Continue (in press).
16. Wonder or miracle drugs: Sulfonamides, penicillin, streptomycin, Aureomycin, Terramycin, Chloromycetin, ACTH, cortisone, and others.
17. Davison, W. C.; Davison, A. T. S.; Swett, E. G.; Hetherington, D. C., and Callaway, J. L.: The First Twenty Years: A History of the Duke University Schools of Medicine, Nursing and Health Services, and Duke Hospital, 1930 to 1950, Durham, N. C., Bull. Duke University, Vol. 24, No. 7-A (May) 1952.
18. Bierring, W. L.: A Golden Epoch in American Medicine, Pharos. 16: 12-21 (Nov.) 1952; Davison, W. C.: The Golden Age of Medicine (in press).
19. Davison, W. C.: John Howland: Seventy-fifth Anniversary of His Birth, J. Hist. Med. & Allied Sc. 5:197-205, 1950; idem: Undergraduate and Postgraduate Pediatric Education in Medical Schools, Am. J. Dis. Child. 76:542-552 (Nov.) 1948; idem: Changes in Pediatric Practice (in press); Park, E. A.: John Howland Award Address, Pediatrics 10:82-108 (July) 1952.
20. Blue, W. B., and Davison, W. C.: The Evolution of Infant Feeding and the Advantages and Disadvantages of Soured Milk Mixtures (in press); Seymour, C. F., and others: Substitution of Vinegar (Acetic Acid) for Lactic Acid in Infant Feeding Mixtures (in press).
21. Sherwood, M. M., and Davison, W. C.: The Pediatric Shift, MD 5:269-273, 283-284 (Nov.) 1950; Davison, W. C.: The Pediatric Shift, J. Pediat. 40:536-538 (April) 1952; Bost, R. B., and Bestebreurtje, A. M.: Reduction of Pediatric Disease at Duke Hospital, 1930 to 1950 (in press).
22. What the Doctor Ordered, Time 60:38-44 (Aug. 18) 1952.
23. Evans, L. J.: Personal communication.
24. Evans, L. J.: Medical Education for Insight, Am. J. Orthopsychiat. 19:585-591 (Oct.) 1949; idem: The Next Twenty Years in Medicine, J. M. Educ. 27:326-329 (Sept.) 1952; Association of American Medical Colleges: Widening Horizons in Medical Education: A Study of the Teaching of Social and Environmental Factors in Medicine 1945-1946, New York, Commonwealth Fund, 1948; Robinson, G. C.: The Patient as a Person, New York, Commonwealth Fund, 1939; Sigerist, H. E.: The University at the Crossroads: Addresses and Essays, New York, Henry Schuman, 1946; Richardson, H. B.: Patients Have Families, New York, Commonwealth Fund, 1945; Kemp, H. A.: Teaching of Social Medicine: Who Will Bell the Cat? South. M. J. 44:1076-1083 (Nov.) 1951; Hubbard, J. P.; Mitchell, J. M.; Poole, M. L., and Rogers, A. M.: Family in Training of Medical Students, J. M. Educ. 27:10-18 (Jan.) 1952; Meleney, H. E., and Mortara, F.: Medical-Social Family Studies in Medical Education, ibid. 27:19-23 (Jan.) 1952; Hollender, M. H., and Galvin, J. A.: Teaching the Psychological Approach to Everyday Medical Problems, ibid. 27:182-183 (May) 1952; Thorne, F. C.: Training the Student in Medical Psychology, ibid. 27:253-257 (July) 1952; Shryock, R. H.: Changing Outlooks in American Medicine Over Three Centuries (in press); Hinsey, J. C.; Diehl, H. S.; West, M. D.; Barclay, R. W.; Weiskotten, H. G.; Altenderfer, M. E.; Stalnaker, J. M.; Darley, W.; Berry, G. P., and Smiley, D. F.: Medical Education Today, Its Aims, Problems and Trends, J. M. Educ. Special Supplement, 1953; Turner, E. L.: Changing Panorama of Medical Care and Some of Its Implications in Medical Education, Northwest M. 52:295-298 (April); 377-379 (May) 1953; Deitrick, J. E., and Berson, R. C.: Medical Schools in the United States at Midcentury, New York, McGraw-Hill Book Company, Inc., 1953.
25. Davison, W. C.: Medical Education in Europe, J. A. M. A. 130:921-924 (April 6) 1946.
26. Scheele, L. A., and Sehrell, W. H. Jr.: Medical Research and Medical Education, Science 114:517-521 (Nov. 16) 1951; Chesney, A. M.: Medical Education and Medical Research Are Part and Parcel of the Medical Profession, Maryland M. J. 1:369-377 (Aug.) 1952; Davison, W. C.: Future of Medical Education, J. A. Am. M. Coll. 21:223-235 (July) 1946.
27. Boston University School of Medicine, Third Annual Announcement, May, 1875; Report of Homeopathic Dispensary, Boston, January 1, 1878.
28. Weiskotten, H. G.; Discussion, South. M. J. 23:968 (Oct.) 1930; Sydenstricker, V. P., and Lee, F. L.: Domiciliary Medicine at University of Georgia School of Medicine, J. A. Am. M. Coll. 14:88-92 (March) 1939; Bakst, H. J.: Domiciliary Medical Care Program as an Integrated Facility in Medical Curriculum, J. A. Am. M. Coll. 25:406-416 (Nov.) 1950; Bailey, A. A., and Weiskotten, H. G.: Training of the Student in What Is Involved in Adequate Medical Care, J. A. M. A. 109:2136-2137 (Dec. 25) 1937; idem: Problem of Discharged Hospital Patient, Hospitals 13:13-17 (Aug.) 1939; Weiskotten, H. G.: Experiment in Medical Care, J. A. Am. M. Coll. 19:159-166 (May) 1944; Bass, C. C.: New Departure in Medical Curriculum, South. M. J. 23:968-970 (Oct.) 1930.
29. Davison, W. C.: The Preceptorial Program at Duke, Panel Discussion, Proc. Ann. Congress M. Educ. and Licensure, Chicago (Feb. 11) 1952, pp. 28-29; Powers, G. F.: Some Observations on Pediatric Education, J. M. Educ. 28:11-19 (Aug.) 1953.
30. Harris, J. S.; Forhus, W. D.; Smith, D. T.; Handler, P.: Persons, E. L.; Greenhill, M. H., and Wilson, F. K.: The "New Look" at Medical Education, Report to the Duke Medical Faculty, Durham, N. C. (Nov.) 1951.
31. Arena, J. M., and Harris, R. R.; Frequency and Distribution of Diseases in Children, South. Med. & Surg. 97:520-522 (Sept.) 1935; London, A. H. Jr.: Composition of Average Pediatric Practice, J. Pediat. 10:762-771 (June) 1937.
32. Poor, R. S.: Meeting the Health Needs in a Southern State: Florida, South. M. J. 47:174-176 (Feb.) 1954.
33. Spock, B.: Teaching Broader Aspects of Pediatrics, Pediatrics 5:21-23 (Jan.) 1950; Plum, P.: It Is Possible to Do Psychosomatic Pediatrics in a Medical Pediatric Department, Trans. 6th Internat. Congress of Pediat., Zurich, 1950, p. 199; Gunnarsen, Siv: Asthma in Children as a Psychosomatic Disease, ibid., p. 206.
34. Peabody, F. W.: Doctor and Patient, New York, The Macmillan Company, 1939.
35. Davison, W. C.: An M.D. Degree 5 Years After High School, J. A. M. A. 90:1812-1816 (June 2) 1928; Swett, F. H., and Eadie, G. S.: Four Academic Years in Three Calendar Years, J. A. Am. M. Coll. 17:16-23 (Jan.) 1942.
36. Markee, J. E.; Harris, J. S., and Davison, W. C.: Programs to Provide More Physicians, J. M. Educ. 26:437-445 (Nov.) 1951; Stead, E. A. Jr.: Personal communication; Penrod, K. E.: Personal communication.
37. Conference on Premedical Education, Union College, Bios 16:114-240 (Oct.) 1945; Buck Hills Falls Conference, The John and Mary R. Markle Foundation, 1952; Severinghaus, A. E., and others: Preparation for Medical Education in the Liberal Arts College, New York, McGraw-Hill Book Company, 1953.
38. Parran, T. Jr.: Public Health Organization in Denmark, Pub. Health Rep. 42:1417-1445 (May 27) 1927; Bergland, H.: Studying Medicine in Sweden — A Comparison with Our American System, Bull. A. Am. M. Coll. 2:292-296 (Oct.) 1927.
39. Eaton, A. G.: Some Suggested Improvements for Postwar Medical Schools, J. A. Am. M. Coll. 20:364-369 (Nov.) 1945.
40. Conant, J. B.: College Education for Future Doctor, Proc. Ann. Cong. M. Educ. pp. 2-4, 1939; also, J. A. M. A. 112:1655-1657 (April 29) 1939.
41. Eadie, G. S., and Davison, W. C.: Postwar Medical Education, J. A. Am. M. Coll. 20:1-11 (Jan.) 1945; Harrison, T. R.: Tradition — The Rivet in Curriculum, J. A. Am. M. Coll. 21:19-25 (Jan.) 1946; Davison, W. C.: Significance of Present Entrance Requirements, J. A. M. A. 96:1367-1369 (April 22) 1931; idem: Two Additional Years in College Versus Two More Years in Hospital, South. M. J. 22:851-855 (Sept.) 1930.
42. Davison, W. C.: Loan Funds Versus Scholarships for Medical Students, J. A. Am. M. Coll. 17:173-174 (May) 1942.
43. Pankratz, D. S.: The Mississippi State Medical Education Loan Fund, South. M. J. 46:101-104 (Feb.) 1953.
44. Henricksen, G. C., and Davison, W. C.: Cost of Undergraduate Medical Instruction in Endowed School, J. A. M. A. 149:99-104 (May 10) 1952.
45. Snoke, A. W.: Cooperation to Reduce Hospital Bills by Medical and Administrative Staffs, Correspondence, J. A. M. A. 150:713-714 (Oct. 18) 1952; A Cooperative Program to Reduce the Costs of Hospital Care, Editorial, J. A. M. A. 150:696 (Oct. 18) 1952.
46. Davison, W. C.: Should American Medicine Be Socialized? J. A. M. A. 122:1067-1070 (Aug. 14) 1943.
47. Parran, T.: Medical Manpower, J. A. Am. M. Coll. 23:18-29 (Jan.) 1948; Ewing, Oscar R.: The Nation's Health; A Report to the President, 1948; Alleged Shortage of Physicians, Editorial, J. A. M. A. 142:111-113 (Jan. 14) 1950; Rusk, H. A.: Medicine, Mobilization and Manpower, J. A. M. A. 145:1256-1260 (April 21) 1951; Murphy, F. D.: We Need More Doctors, Saturday Evening Post 223:19-21, 82, 85-87 (May 26) 1951.

48. Dickinson, F. G.: Supply of Physicians' Services, J. A. M. A. 145:1260-1264 (April 21) 1951; idem: Revised Keogh-Reed Bills, ibid. 149:1244-1247 (July 26) 1952; idem: How Bad is the Distribution of Physicians? ibid. 154:1209-1211 (April 3) 1954.

49. Davison, W. C.: Opportunities in Practice of Medicine, J. A. M. A. 115:2227-2232 (Dec. 21) 1940.

50. Davison, W. C.: Health Legislation and Shortage of Physicians, J. A. Am. M. Coll. 25:396-405 (Nov.) 1950; also, Connecticut M. J. 15:99-105 (Feb.) 1951.

51. Rawlinson, H. E.: History of Specialization and Its Implications for Today, Canad. M. A. J. 67:266-269 (Sept.) 1952.

52. Weiskotten, H. G.: Present Tendencies in Medical Practice, Bull. A. Am. M. Coll. 2:29-47 (Jan.) 1927; idem: Tendencies in Medical Practice: Study of 1925 Graduates, J. A. Am. M. Coll. 7:65-85 (March) 1932; idem: The Place of the Specialties, Brit. M. J. 2:559 (Sept. 5) 1953; idem, and Altenderfer, M. E.: Trends in Medical Practice, An Analysis of Distribution and Characteristics of Medical College Graduates, 1915-1940, J. M. Educ. 27 (Part 2): 3-41 (Sept.) 1952.

53. Davison, W. C.: Rural General Practice in Groups, J. A. Am. M. Coll. 23:180-189 (May) 1948.

54. Hyman, O. W.: Southern Medical Colleges Must Maintain Enrolment at Least at Its Present Level, J. A. Am. M. Coll. 12:301-304 (Sept.) 1937; idem: Number and Distribution of Physicians in Southern States as Bearing Upon Policies of Southern Medical Colleges, South. M. J. 30:85-89 (Jan.) 1937; Diehl, H. S.: Physicians for Rural Areas: Factor in Their Procurement, J. A. M. A. 145:1134 (April 14) 1951.

55. Commission on Hospital Care: Hospital Care in the United States, New York, Commonwealth Fund, 1947, p. 261.

56. Davison, W. C.: Recruiting and Training Country Doctors, MD 6:85-88 and 104 (March) 1951.

57. Swett, E. G.: Personal communication.

58. Sanger, W. T.: Medical Research in South Grows Apace, South. M. J. 45:60-63 (Jan.) 1952; Hinsey, J. C.: From the Dean's Office, Cornell Univ. M. Coll. Quarterly (March) 1952, pp. 3-5; The Cost of Spending Money, Editorial, J. M. Educ. 27:201-203 (May) 1952.

59. Rothman, P. E.: Quality of Medical Care, Pediatrics 9:243-248 (Feb.) 1952.

Functioning Ovarian Tumors

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The term "function" as applied to a neoplasm may reflect certain histologic alterations, such as the production of bile or mucus by tumor cells. It may apply equally to the elaboration of hormones or other substances that, on gaining entrance to the circulation, effect physiologic alterations in the host. In some instances the pathologist and the physiologist may be able to correlate their findings, whereas in others such correlations may be impossible.

Tumors of ductless glands furnish the best examples of functioning neoplasms, and those of the ovary exhibit the widest range of variability in this regard. Six types of ovarian tumors are the subject of this presentation; 3 are feminizing, 2 are masculinizing and 1 is "neutralizing." In addition, mention will be made of struma ovarii.

Granulosa Cell Tumor

DEFINITION. — Granulosa cell tumor is a functioning, feminizing ovarian tumor comprised of cells resembling in appearance and arrangement the elements of the normal membrana granulosa and, like it, capable of elaborating estrogen.

HISTOGENESIS. — These tumors can be produced experimentally by irradiating the ovaries of immature female mice; it is thought that they arise from the mesenchymal stroma of the ovary rather than from pre-existing membrana granulosa or from the germinal epithelium. These tumors also develop in castrated female rats when bits of their ovaries are transplanted into the spleen. Estrogen elaborated by these grafts is destroyed by the liver before it reaches the general circulation. Development of granulosa cell tumors from such grafts is explained by some investigators on the basis of an unopposed action of pituitary gonadotropin.

INCIDENCE. — Granulosa cell tumors comprise from 2 to 3 per cent of any sizable series of ovarian tumors; about 700 cases have been reported in the literature. Ten per cent of the patients who have such tumors are children, 40 per cent are between puberty and the menopause, and the remainder are older.

SYMPTOMS. — Granulosa cell tumors occurring during preadolescent years induce sexual and somatic precocity with premature onset of vaginal bleeding that, while anovulatory, may be profuse and semiperiodic. Amenorrhea is seen in 50 per cent of sexually mature women having such tumors, and it may reflect a high level of circulating estrogen produced by the lesion. Other patients may bleed irregularly. Infertility is an almost constant feature since ovulation from the sound ovary is hormonally suppressed. Semiperiodic menstrual-like bleeding is the rule in postmenopausal women. Tenderness of the breast may be present.

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Diagnosis. — When the afore-mentioned symptoms are manifest, all but the smaller causative ovarian tumors will be palpable. The concomitant finding of a large uterus is confirmatory evidence.

Laboratory studies of assistance include the demonstration of excessive quantities of urinary estrogen. Bio-assays of tumor tissue may show the presence of this substance. A decrease in the level of circulating estrogen will be manifest by uterine bleeding within 24 hours of operation in those patients in whom the ovarian tumors have been treated by local extirpation.

Pathologic Features. — At operation, the tumors are sizable growths that may be solid or cystic. They are unilateral in 95 per cent of cases. Lobulation or encapsulation is the rule, but 20 per cent are malignant and are adherent to surrounding structures. This feature is seen more frequently among older patients. The enlarged uterus contains an independent, hormonally induced carcinoma in about 20 per cent of cases of granulosa cell tumors affecting women more than 50 years of age.

The microscopic features include a basic composition of small prismatic granulosa-like tumor cells disposed in rosettes, cords and irregular strands. Admixture with typical theca cells is frequently observed, and both granulosa and theca elements may exhibit areas of luteinization. Mitotic figures are generally infrequent except in the aggressive tumors observed chiefly in older patients. In other instances the dividing line between benign and malignant lesions can be appraised only through the "retrospectoscope" in analyses of cases after five and 10 years.

Treatment and Prognosis. — About 20 per cent of granulosa cell tumors recur and metastasize. Such spreading tendencies usually can be anticipated in connection with poorly encapsulated growths, especially in older patients. The use of conservative surgical procedures is indicated for young persons, whereas the employment of more radical measures for those more than 50 years of age appears logical. Pregnancy is possible after simple removal of a granulosa cell tumor in a young person. Endometrial carcinoma may be found at panhysterectomy for granulosa cell tumor in an older patient. The tumors themselves are radiosensitive, and use of radiotherapeutic procedures should be kept in mind to prevent recurrence from locally invasive tumors.

Theca Cell Tumor

Definition. — A theca cell tumor is a solid ovarian tumor composed of cells resembling those of the theca folliculi. Such a tumor occasionally produces enough estrogen to feminize its host.

Histogenesis. — Anatomic studies plus results of experimental production of these tumors by roentgen rays in immature female mice indicate an origin from the ovarian stromal mesenchyme. The frequent occurrence of combined granulosa and theca cell tumors in humans favors derivation from a common ancestral cell.

Incidence. — Approximately 125 examples of this tumor have been reported since its first description in 1932. The tumors are rarely seen in persons less than 30 years of age. Two thirds of the growths occur in the postmenopausal period.

Symptoms. — These are essentially the same as those described for granulosa cell tumor, but features of feminization are usually not so pronounced since theca cell tumors do not so regularly elaborate significant quantities of estrogen. In 20 per cent of cases the associated uterine bleeding results from estrogen-induced carcinoma of the endometrium.

Diagnosis. — Physical findings and results of laboratory studies in the average case are such that the correct preoperative diagnosis will not often be made.

Pathologic Features. — These unilateral tumors are most often diagnosed surgically as fatty fibromas because of their encapsulation and orange-yellow color. They are nearly all solid and average 5 to 10 cm. in diameter. The contralateral ovary is often atrophic because of estrogen-induced suppression of function. Nevertheless, the uterus is unusually "large and healthy" except for the frequent association of myomas. Cut surfaces of the tumor show a fibrous composition and a tan-yellow color.

Microscopically, a composition of fat-laden plump spindle cells arranged in bundles with intervening fibrous and hyaline bands is typical. In the absence, however, of occasional clusters of granulosa cells, the hallmark of a "mixed" tumor, differentiation from fibroma may be difficult. This diagnostic dilemma occasionally may be resolved by histochemical studies.

Treatment. — Although nearly all theca cell tumors are benign, their occurrence among older women and their frequent association with en-

dometrial carcinoma temper the need for conservatism. Removal of the uterus in these cases is good prophylaxis with regard to carcinoma.

Sertoli Cell Tumor

Perhaps the less said about these tumors the better, inasmuch as they are well established entities chiefly in the veterinary literature, in which they are best known as feminizing testicular tumors of dogs. The occurrence, however, of certain feminizing testicular growths in human males has led to a search for their homologous counterparts in human females. To many investigators, the tubular elements in arrhenoblastomas are estrogen-producing Sertoli cells; if it is correct, this observation provides a ready explanation as to why the more mature or differentiated arrhenoblastomas fail to masculinize as much as would be expected. It has been declared that the so-called tubular variant of granulosa cell tumor is actually a testicular Sertoli cell tumor of the ovary. Whether or not these intermediate tumors are actually Sertoli cell growths (androblastomas) remains to be seen. Meanwhile, it must be admitted that in certain cases the sexual pattern of the patient may be the reverse of that predicted as the result of microscopic evaluation of the tumor.

Arrhenoblastoma

Definition. — Arrhenoblastoma is a defeminizing or masculinizing ovarian tumor that exhibits somewhere in its microscopic makeup a composition suggestive of testicular tissue.

Histogenesis. — With the occurrence in the ovarian hilus of tubular structures accepted by many observers as being potentially, if not actually, testicular, an origin from these male-directed elements becomes a palatable theory. This notion is perhaps strengthened by the occurrence of arrhenoblastomas in ovotestes. Some of the tumors, however, exhibit nontesticular elements, and some investigators champion the idea of a teratomatous origin.

Incidence. — Approximately 100 cases have been reported. For the most part, arrhenoblastomas affect women of child-bearing age.

Symptoms. — These are typically those of defeminization and masculinization. Featured are amenorrhea with sterility, a masculine type of hairiness, atrophy of the breasts, hypertrophy of the clitoris and disturbing changes in the voice. Increased blood pressure, edema and plethoric obesity are usually absent. The causes of masculinization are legion, and by no means will every hairy woman seen in office practice have an arrhenoblastoma; however, the likelihood of this lesion in such a patient is heightened considerably by palpation of a solid pelvic adnexal tumor.

Diagnosis. — Results of laboratory studies may reveal low values for urinary estrogen and elevated values for urinary ketosteroids. Not definitely essential in the diagnosis, these findings are the garnishments of a good case report.

Pathologic Features. — These tumors are unilateral, moderate in size, semiencapsulated, solid and gray. They characteristically exhibit multicentric lobulation, like a cirrhotic liver. The uterus is smaller than normal and the contralateral ovary shrunken and atrophic.

The microscopic picture is variable, but in all instances one finds scattered clusters of pale, fat-filled cells resembling interstitial cells of the testis. (Certain ovarian hilar areas of proliferation seen in masculinized women are composed entirely of these interstitial cells; such areas scarcely deserve the designation of tumors, but they are mentioned for the sake of completeness.) The bulk of the arrhenoblastoma is, however, made up of other elements. In so-called differentiated lesions, tubules predominate. These are lined by columnar cells reminiscent of those seen lining the tubuli recti; they are not spermatogonial cells, and they contain droplets of fat. They have been interpreted by some workers as Sertoli cells. At the other end of the scale, the appearance, except for the afore-mentioned interstitial cells, is that of prismatic and spindle elements intermingled in a pattern practically indistinguishable from granulosa and theca cell tumors. It is these immature, or "undifferentiated," arrhenoblastomas that are the most active masculinizers. Definite teratomatous characteristics may be evident in some arrhenoblastomas.

Treatment. — The occurrence in young women and the gross encapsulation of the tumors, plus the disappearance of symptoms and the possibility of pregnancy after local removal, have been factors directing a policy of surgical conservatism in the treatment of arrhenoblastomas. Prolonged follow-up, however, reveals more than a 50 per cent chance for recurrence and metastasis, occurring five or even 10 years after operation. In view of these unfavorable late results, the additional sacrifice of the uterus, the tubes and the unin-

volved ovary would appear justifiable in many cases.

Masculinovoblastoma

Definition. — Masculinovoblastoma is a primary ovarian neoplasm that possesses the pathologic features of an adrenal cortical carcinoma and that produces the clinical picture of Cushing's syndrome.

Histogenesis. — To some, this neoplasm is explained most logically by means of growth of adrenal cortical rests in the ovarian hilus. Others regard the rest theory as redundant, since in adrenalectomized ground squirrels the ovarian stroma assumes the histologic appearance and physiologic function of adrenal cortex. A teratomatous derivation remains another unproved possibility.

Incidence. — Reports of about 20 authenticated cases comprise the literature on this rare type of ovarian neoplasm. Like arrhenoblastoma, masculinovoblastoma tends to affect women during the period of fertility.

Clinical Features. — To the masculinization that characterizes arrhenoblastoma, must be added plethoric obesity, hypertension, diabetes, polycythemia and other features of Cushing's syndrome. The finding of a solid tumor in a patient exhibiting these features enabled my colleagues and me, on one occasion, to make the correct preoperative diagnosis.

Results of laboratory and hormonal studies are characteristic of the pattern seen in adrenal cortical hyperplasia or tumor.

Pathologic Features. — The tumors are solid, thinly encapsulated, unilateral and of moderate size. They are distinctively orange-yellow in color, like theca cell tumors; unlike the latter, however, they are soft and friable, with a distinct tendency to develop zones of hemorrhage and necrosis.

A trabecular and alveolar grouping of large polygonal fat-filled cells at once suggests the picture of an adrenal rather than an ovarian tumor. Pleomorphism is pronounced and mitotic figures are numerous in the more malignant tumors. Glycogen may be demonstrated in the tumor cells.

Treatment. — Results in a small number of patients treated surgically and followed for five years indicate that the prognosis is good in spite of the fact that most of the lesions have been handled conservatively. It would appear, however, that infiltrative and cytologically active tumors of this type demand hysterectomy with bilateral salpingo-oophorectomy.

Dysgerminoma

Definition. — Dysgerminoma is an ovarian tumor that microscopically is identical to seminoma. It is the commonest tumor of the pseudohermaphroditic gonad. Because of this latter fact and the observation that otherwise normal women who have the neoplasm are frequently infertile, the growth has a weak claim to the caption of "neutralizing" tumor.

Histogenesis. — The point of origin of an exactly similar tumor, the afore-mentioned seminoma, has been traced in the dog to the spermatogonial elements of the testis. It has been found that embryonic male and female gonads both contain elements somewhat similar to the cells in dysgerminoma. Most investigators dismiss the matter of origin with the noncommittal statement that the tumors spring from neuter or dysgerminomal sex cells.

Incidence. — The approximately 300 case reports in the literature do not indicate the true incidence of this tumor, since many dysgerminomas removed surgically have been labeled atypical sarcomas of the ovary. Unlike seminoma, which affects middle-aged men, the majority of ovarian dysgerminomas occur in women who are less than 20 years of age.

Symptoms. — The early reported association of this tumor with clinical pseudohermaphroditism gave rise to misdirected concepts of a cause-and-effect relationship between the two conditions. Most of the tumors reported currently have occurred among otherwise normal women, including some who were pregnant at the time of the tumor's discovery. Like seminoma, dysgerminoma is likely to grow rapidly.

Pathologic Features. — Bilateral in almost a third of the cases, these tumors are generally large and solid; they are invested with a thin capsule. Their consistency is almost like that of brain tissue. Hemorrhage and necrosis are commonly seen on the cut surfaces. Growths that are bilateral or adherent are likely to prove fatal.

Histologically the picture features a monotony of large, round, hyperchromatic cells in a mosaic, with scattered sprinkling of lymphocytes. Mitotic figures are frequent in the large cells, and the

lesions are always highly malignant cytologically.

TREATMENT. — Surgeons in the past have been much more influenced by the body curves of the patients than by the mortality curves emerging from long-term follow-up studies in series of dysgerminomas. Reluctance to castrate has influenced surgical treatment, and a discouraging five year survival rate of 30 per cent has been the result. The tumors are radiosensitive, but here again reluctance invites delay in the institution of roentgen therapy until the onset of incurable recurrent lesions or independent neoplasia in the opposite ovary. Fortunately, with the present day availability of satisfactory replacement therapy with sexual hormones, more surgeons are gauging the treatment of dysgerminomas on the basis of their known malignant proclivities.

Struma Ovarii

Struma ovarii is an ovarian teratoma of thyroid tissue. Twenty per cent of ovarian teratomas contain thyroid tissue; in more than 120 reported cases, this element had overgrown to such an extent as to make the resulting tumor an ovarian goiter. In 5 per cent of these cases, clinical evidence of thyrotoxicosis was present, which sometimes led to unnecessary operations on the neck in an effort to prepare the patient for a major pelvic operation. Radioiodine in tracer doses is the current answer to these anomalous situations.

Pathologically, these tumors resemble nodular rather than exophthalmic goiters. Ascites is a frequent accompaniment, and malignant change is observed in 5 per cent of the lesions.

The Clinical Differentiation of Congenital Heart Lesions Amenable to Surgery

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Physicians can no longer be satisfied with a simple diagnosis of congenital heart disease. The impetus given to the surgical treatment of conditions of this type by Gross and Hubbard's patent ductus arteriosus ligation technic in 1939, and by the Blalock-Taussig shunt operation for tetralogy of Fallot in 1945, has made it imperative that we try to make an accurate diagnosis in each case, in order to identify those cardiac anomalies that can be benefited by surgery.

The new diagnostic aids, including cardiac catheterization and angiocardiography, have been invaluable in this direction. They have made it possible for us to understand the physiologic effects of most of the congenital cardiac defects. With this knowledge of hemodynamics, we should be able accurately to diagnose the type of lesion present in the great majority of cases with the aid of simple clinical methods, such as roentgenography, fluoroscopy, and electrocardiography, provided we make a thorough physical examination and study each patient from the functional point of view, correlating each sign or symptom observed with the dynamic processes that are likely to produce them.

It is the purpose of this report to review the diagnosis of those congenital heart lesions that are amenable to surgery at the present time. Let us, however, first briefly outline some of the important points to be looked for in the history and physical examination in cases of this type.

1. Dyspnea on effort is significant since the degree to which it is present is usually proportional to the severity of the lesion.

2. Cyanosis by its presence or absence enables us to limit the diagnostic possibilities in each particular case. Central cyanosis always implies a right-to-left shunt, such as in tetralogy of Fallot. In noncyanotic cases there is either a left-to-right shunt as in atrial septal defects and typical patent ductus arteriosus, or none as in coarctation of the aorta. The date of onset and persistence of cyanosis are important. We have all come across cases of atrial septal defect in which the child was cyanotic at birth and remained so only for two or three weeks; those of tetralogy of Fallot

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in which cyanosis was not detected until the child was about the age of two to three months; and those of Eisenmenger's complex in which cyanosis was not perceptible until later in life or when the patient had become an adult.

3. Clubbing of fingers and polycythemia usually accompany cyanosis.

4. Squatting is characteristic in cyanotic cases with diminished pulmonary flow.

5. Loud, rough systolic murmurs along the left sternal border are one of our most valuable clues to the existence of congenital heart conditions.

6. Dysphagia, stridor and frequent infections of the upper part of the respiratory tract form a triad which is a common finding in cases of aortic ring or anomalous right subclavian artery.

7. Headaches are frequent in cases in which cyanosis is present.

8. Syncope and angina are occasionally present in cases of isolated pulmonary stenosis or in those in which congenital heart lesions are associated with pulmonary hypertension.

The general development of the patient also may be of diagnostic assistance. Certain lesions, such as large atrial septal defects and patent ductus arteriosus, are associated with severe stunting of growth, whereas others, like isolated pulmonary stenosis, do not as a rule impair development.

Precordial bulge is usually associated with cardiac enlargement of considerable degree and is most commonly present in large atrial septal defects, large ventricular septal defects, or patent ductus arteriosus.

Examination of the heart should stress the following:

1. The point of maximal impulse must not be confused with the apex beat, although both may coincide. Normally, the point of maximal impulse is located at the fifth interspace just inside the midclavicular line. In left ventricular enlargement, the point of maximal impulse is coincident with the apex beat which is displaced downwards and outwards. In right ventricular hypertrophy, the point of maximal impulse is located at the third and fourth left interspaces near the sternum, and the apex beat is usually felt as a faint tap at the fourth or fifth interspace near the midclavicular line.

2. Thrills should be palpated for, and, of course, murmurs must be noted, also the points at which they are most intense and the direction of their transmission. Sometimes we may be in doubt as to whether a loud, rough systolic murmur, which is most intense at the second and third left interspaces near the sternum, is caused by a patent ductus arteriosus or a ventricular septal defect. It is worth while then to remember that patent ductus murmurs are usually transmitted upwards towards the clavicle, whereas ventricular septal defect murmurs are transmitted downward, along the left sternal border.

3. The second heart sound over the pulmonary area is significant. Is it accentuated, faint or absent, split or pure? A split pulmonary second sound signifies that both the aortic and pulmonary valves are present and functioning. In pulmonary stenosis, the second pulmonary sound is usually absent or faint; on occasion, however, it may be loud, but it is always pure. In atrial septal defect, it is widely split; in Eisenmenger's complex, it is especially loud and closely split.

Both radial and femoral pulses should be palpated. The absence of femoral pulses, especially in the presence of hypertension of the upper extremities, is almost pathognomonic of coarctation of the aorta.

Blood pressure should always be determined in the right arm, for it is known that there are cases of coarctation of the aorta, involving the left subclavian artery or just above it, in which there will be a normal or low pressure in the left arm. In suspected cases of patent ductus arteriosus versus ventricular septal defect, the blood pressure is sometimes especially helpful in differentiating the two conditions. In patent ductus, the pulse pressure usually tends to be wide; whereas in ventricular septal defect, it is normal or narrow.

On electrocardiographic examination, high, pointed P_2 is usually indicative of right atrial hypertrophy. Auriculoventricular blocks are common in septal defects, especially those of the atria. Right bundle branch block, complete or incomplete, is practically always present in capacity enlargement of the right ventricle, such as in atrial septal defects. Finally, the study of the unipolar chest leads will frequently be of even more help than roentgenograms in demonstrating whether there is left or right ventricular hypertrophy, or both.

Fluoroscopic and roentgen examination of the chest is also helpful for, in addition to determining which chambers of the heart are enlarged, we

should evaluate the condition of the lungs. Are they congested or clear? If congestion is present, does it extend out to the periphery, as in atrial septal defects, or only up to about the mesial third, as in ventricular septal defects? Are the pulmonary arteries prominent? Do they pulsate, and if so, to what degree? This should be noted especially in the branches of the secondary pulmonary arteries, where expansile pulsations are normally absent or just barely visible.

Let us now consider the more common congenital heart lesions that are amenable to surgery at the present time.

Coarctation of the Aorta

The development is usually normal. There may be no symptoms. Cyanosis is absent. Leg aches are a common complaint, and there may be headaches and dyspnea on effort, especially if there is hypertension of the upper extremities of considerable degree.

On physical examination, the point of maximal impulse is forceful and coincides with the apex beat, and there is usually a loud, rough systolic murmur along the left sternal border. The diagnosis is confirmed by the findings of a strong radial pulse and absent or weak femoral pulses, with blood pressure lower in the legs than in the arms.

The electrocardiogram shows left ventricular hypertrophy. On fluoroscopy, there is usually dilatation of the ascending aorta, and although the heart may not appear enlarged, careful examination will show concentric hypertrophy of the left ventricle. Occasionally, there is a second indentation on the left side of the barium-filled esophagus, just below the aortic arch, which is produced by a dilatation of the poststenotic segment of the coarcted aorta. Notching of the ribs is usually observed in adults.

Aortic Rings

The symptoms will depend on the degree of constriction of the trachea and esophagus by the ring. If this is severe, there will usually be stridor, dysphagia and frequent infections of the upper part of the respiratory tract.

On physical examination, the heart usually appears normal in size, and there may or may not be murmurs at the base. The diagnosis is made by roentgenograms and fluoroscopy, which show that both the right and left sides of the barium-filled esophagus are indented by the ring at the level of the aorta in the posteroanterior view, and also anteriorly and posteriorly at the same level in the right anterior oblique and lateral views.

Patent Ductus Arteriosus

The typical case is characterized by the absence of cyanosis, and there may be stunting of growth and slight to moderate dyspnea on effort. If associated with pulmonary hypertension, cyanosis may be present and will be more pronounced in the lower than in the upper extremities.

The cardiac findings are: (1) The point of maximal impulse forceful and heaving at the apex, which is displaced downwards and outwards; (2) a systolic or systolic and diastolic thrill at the pulmonic area; (3) a systolic impulse at the second left interspace; (4) P_2 split and accentuated, when heard; (5) in the typical case, a continuous, machinery-like systolic and diastolic rough murmur at the pulmonic area, best transmitted towards the clavicle, which frequently, in children under 4 years of age and in cases associated with pulmonary hypertension, is heard only during systole; and (6) a wide pulse pressure.

The electrocardiogram may be normal, or it may show evidence of left ventricular hypertrophy.

The roentgenographic and fluoroscopic findings are: The lungs appear congested, although usually not as much as in cases of atrial septal defect. On fluoroscopy, the branches of the secondary pulmonary arteries are seen to pulsate 2 to 3 plus. The pulmonary artery trunk is usually prominent and pulsates strongly. The left ventricle and left atrium are usually enlarged; occasionally, if the ductus is large, there may be some enlargement of the right ventricle also.

Differential diagnosis includes: 1. Venous Hum. This is usually softer and is accentuated in diastole. It may be obliterated by pressure on the jugular vein or by turning the head towards one side.

2. Aortic Stenosis and Insufficiency. The murmur is usually loudest over the aortic area, and the diastolic murmur, which is usually blowing, is transmitted downwards along the left sternal border.

3. Aortic-Pulmonary Artery Septal Defect. The findings in this condition are practically the same as those in patent ductus arteriosus, and cannot be differentiated even by catheterization unless the catheter is actually passed through a ductus or through the aortic window.

4. Rupture of a Sinus of Valsalva into the Right Ventricle. Although the murmur and thrill are usually lower and there is greater enlargement of the right ventricle than in patent ductus arteriosus, the clinical differentiation usually depends on cardiac catheterization.

5. Atrial Septal Defect. This may cause confusion because it produces a systolic murmur over the pulmonic area, but is easily differentiated in that it is associated with right atrial and right ventricular enlargement, but never with hypertrophy of the left ventricle — a cardinal sign of patent ductus arteriosus.

6. Ventricular Septal Defect. When patent ductus arteriosus is manifested only by a systolic murmur, it may be difficult to differentiate it from high ventricular septal defects. Both are usually accompanied by a systolic thrill, but the murmur of patent ductus arteriosus is transmitted upwards towards the clavicle, whereas that of a ventricular septal defect is transmitted downwards along the left sternal border. The pulse pressure is usually wider in patent ductus arteriosus. The electrocardiogram and fluoroscopy in ventricular septal defect usually show enlargement of both the right and left ventricles.

Isolated Pulmonary Stenosis

The development is usually normal. There is moderate to severe dyspnea on effort, no cyanosis, and rarely, angina and syncope.

The cardiac findings are: (1) The point of maximal impulse at the third and fourth left interspaces near the sternum; (2) the apex beat palpated as a tap in the fourth or fifth left interspace at or inside the midclavicular line; (3) no systolic impulse at the pulmonic area; (4) a systolic thrill and a loud, rough systolic murmur at the second and first left interspaces near the sternum; (5) P_2 absent, or faint and pure; and (6) the blood pressure normal or low.

The electrocardiogram is characterized by pronounced right axis deviation with right ventricular hypertrophy in the unipolar chest leads. Occasionally, there may be high, pointed P waves in leads II and V_1. On fluoroscopy, the lungs are clear, especially towards the periphery. There is usually prominence of the pulmonary artery trunk which may pulsate normally, but pulsations in the branches of the secondary pulmonary arteries are always absent. There is hypertrophy of the right ventricle and, frequently, prominence of the right atrium. Occasionally, the stenosis is present at the infundibular area instead of at the valve; in such cases, the murmur may be most intense at the third left interspace, and usually no poststenotic dilatation of the pulmonary artery is seen on fluoroscopy.

Pulmonary stenosis may be associated with an atrial or a ventricular septal defect and a normal aortic root. In such cases, the findings will depend on which lesion is predominant, and cyanosis will be present if the shunt is from right to left.

Differential diagnosis includes: 1. Ventricular Septal Defect. Pulmonary stenosis, especially the infundibular type, must be differentiated from the Roger type of ventricular septal defect. In both, the murmur and thrills are most intense at the third left interspace near the sternum, and on fluoroscopy no cardiac enlargement may be detected. In the Roger type of ventricular septal defect, however, the electrocardiogram is practically normal, whereas in infundibular stenosis right axis deviation or pronounced right ventricular hypertrophy is evident.

2. Atrial Septal Defect. If the patient has been carefully examined, there should be no difficulty in differentiating pulmonary stenosis from this condition. Whereas a thrill is always present in pulmonary stenosis, it occurs only in about a third of the cases of atrial septal defect. In atrial septal defect, there is a systolic impulse at the second left interspace, which is not palpable in pulmonary stenosis. The electrocardiogram in atrial septal defect almost always shows an incomplete or complete right bundle branch block, which is rarely present in pulmonary stenosis. Fluoroscopy definitely differentiates the two conditions, for in atrial septal defect, besides the great enlargement of the right ventricle and right atrium, there is always congestion of the lung fields out to the periphery and pronounced pulsations of the branches of the secondary pulmonary arteries.

Tetralogy of Fallot

Development is usually poor. Cyanosis may not become permanent until the third or fourth month of life, although there may be paroxysmal attacks of dyspnea and cyanosis early in infancy. Clubbing and polycythemia are usually present, and there is a history of severe dyspnea on effort relieved by squatting.

The cardiac findings are: (1) The point of maximal impulse at the third and fourth left interspaces near the sternum, with a faint apex tap in the fourth or fifth left interspace inside the midclavicular line; (2) a systolic thrill along the left sternal border, present in about 60 per cent of the cases, and no systolic impulse at the second left interspace; (3) a loud, rough systolic murmur in the second and third left interspaces near the sternum; (4) P_2 usually faint or absent, occasionally accentuated, but always pure; and (5) the blood pressure normal or low. Thus the heart findings in tetralogy of Fallot are practically those of pulmonary stenosis in a cyanotic person.

The electrocardiogram shows right axis deviation and right ventricular hypertrophy in the unipolar chest leads.

Roentgenographic and fluoroscopic findings are: The lung fields are clear, especially towards the periphery, and there are no expansile pulsations of the secondary pulmonary artery branches. The over-all size of the heart is normal or small. There is a concavity of the left upper border, and the apex is usually displaced upwards. There is hypertrophy of the right ventricle and usually some prominence of the right atrium. It should be remembered that in about 25 per cent of the cases the aorta arches and descends on the right.

Differential diagnosis includes: 1. Pulmonary Stenosis with Atrial Septal Defect and Right-to-Left Shunt. In this condition, although the right ventricle and right atrium are usually larger than in tetralogy of Fallot, the differential diagnosis depends on catheterization or angiocardiography.

2. Pulmonary Stenosis with Ventricular Septal Defect and Right-to-Left Shunt. Clinical differentiation from tetralogy of Fallot is practically impossible, and the diagnosis must be made by catheterization.

3. Eisenmenger's Complex. Cyanosis usually appears late in life. On physical examination, there is a strong systolic impulse at the second left interspace and the pulmonary second sound is accentuated and closely split. On fluoroscopy, the pulmonary arteries are prominent, and there are always pronounced pulsations of the branches of the secondary pulmonary arteries.

4. Transposition of the Great Vessels. The heart is usually greatly enlarged, with involvement of both the left and right ventricles. The pulmonary second sound is usually split, indicating the existence of two valves and of adequate pulmonary circulation.

5. Tricuspid Atresia, with Pulmonary Stenosis and Normal Origin of the Great Vessels. The history is usually one of cyanosis since birth, dyspnea and squatting. In contradistinction to tetralogy of Fallot, the heart is usually enlarged and the point of maximal impulse is located at the apex, which may be displaced downwards and outwards. On fluoroscopy and roentgen examination, the lungs are clear, there are no pulsations of the branches of the pulmonary secondary arteries, and there is enlargement of the left ventricle. The electrocardiogram will clinch the diagnosis, for this is about the only cyanotic heart condition with left axis deviation and left ventricular hypertrophy.

Summary

A great number of cases of congenital heart disease amenable to surgery can be diagnosed clinically by means of a careful history and physical examination combined with electrocardiographic, roentgenologic and fluoroscopic findings. Coarctation of the aorta, aortic rings, patent ductus arteriosus, isolated pulmonary stenosis and tetralogy of Fallot are discussed from the standpoint of clinical differentiation.

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The Complex Electrocardiogram

Francis A. Reed, M.D.
MIAMI BEACH

In cases of coronary occlusion with myocardial infarction giving a typical history and unequivocal electrocardiographic findings there is rarely any doubt as to the diagnosis of the principal underlying pathology. The presence of complicating factors of this condition must be evaluated by a complete cardiologic examination and treated as indicated.

It is, in the main, the conditions in which patients who have had one or more infarctions in the past, or a former disturbance in the conduction system, who now present themselves with symptoms suggestive of a fresh infarct that cause confusion. This confusion is, in a large measure, due to a complex electrocardiogram because of residual electrocardiographic changes from the old infarct or disturbances of the conducting mechanism. The electrocardiographic evidence of a fresh infarct may be obscured in such cases. It is my purpose here to discuss such complex electrocardiograms.

To facilitate the understanding of such tracings a brief review of the underlying factors responsible for the QRS deflections in the normal electrocardiograms, in bundle branch block and in myocardial infarction are presented.

Figure 1 shows the spread of ventricular excitation when intraventricular conduction is normal, in left bundle branch block and in right bundle branch block. It will be seen that in normal activation the right ventricular cavity potential is initially positive and then negative throughout the remainder of the period of electrical systole. This cavity potential in the right ventricle D is manifested in the electrocardiogram by a small R and deep broad S. The R is a result of the earlier activation of the septum from left to right. This is also transmitted through the resting wall of the right ventricle as seen in the complex E, close to the outside wall of the right ventricle. The deep broad S in D is due to excitation of the free wall of the left ventricle acting in a direction away from the cavity of the right ventricle plus excitation of the subendocardial wall of the right ventricle acting again away from the right ventricular cavity towards the epicardium.

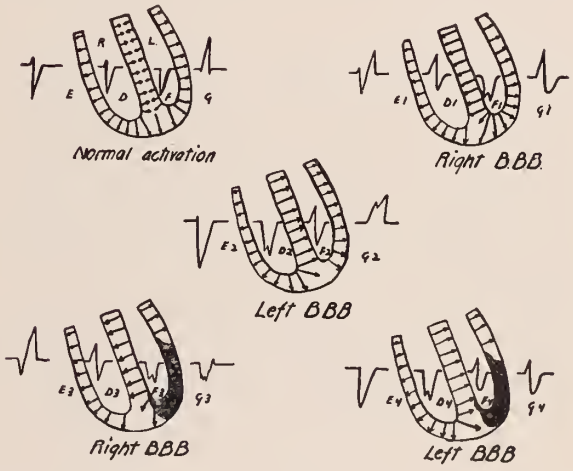


Figure 1

The complex in E shows a deep S due to preponderance of electrical forces of excitation acting away from that lead in excitation of the thicker wall of the left ventricle, overcoming the weaker electrical effect of activation of the free wall of the right ventricle acting in a direction towards that electrode. The cavity of the left ventricle is negative, F, through the entire phase of ventricular electrical systole as activation of both the interventricular septum and free wall of the left ventricle is always in a direction away from that cavity. Complex G shows a small Q representing transmission of the earliest activation of the septum from left to right. The tall R in G1 is due to activation of the free wall of the left ventricle acting in a direction toward that lead.

Chief of Medicine, St. Francis Hospital, Miami Beach.

Read before the Southeastern Regional Meeting of the American College of Physicians, Sea Island, Ga., Oct. 18, 1953.

In right bundle branch block it is seen that the cavity potential D1 of the right ventricle is initially more strongly positive as manifested by a taller R due to complete activation of the septum in the initial phase from left to right. The direction of the excitatory process through the entire wall of the septum is towards the right ventricular cavity. The S is due to negativity of the cavity resultant from excitatory processes now acting away from the cavity, that is, through the free walls of the right and left ventricles. The small R in E1 is due to initial early activity through the septum causing the initial positivity of the right ventricle cavity and transmitted through the free wall of the resting right ventricular muscle. The S is resultant from a transmission, also through the free wall of the resting right ventricular muscle, of the negativity of the right ventricular cavity resultant from activation now of the free wall of the left ventricle. The late R is brought about by the late activation of the free wall of the right ventricle acting in a direction towards that lead. The cavity potential of the left ventricle F1 again is negative throughout the entire electrical ventricular systole as the excitatory process is acting away from the cavity throughout the QRS phase. In G1 the R is due to preponderance of the electrical force acting in a direction towards that electrode in passage through the thicker free wall of the left ventricle than the electrical force acting away from the electrode in activation of the interventricular septum. At times a small Q may be seen because of early activation of the septum as compared to activation of the free wall of the left ventricle. The late S is due to late activation of the subendocardial surface of the wall of the right ventricle. This is the last part of the ventricular muscle to be activated and hence is unopposed. It is acting in a direction away from this electrode.

In left bundle branch block cavity potential D2 of the right ventricle is negative through electrical systole as all electrical forces in activation of both the right ventricle wall and the interventricular septum are in a direction away from the cavity. In E2 early activation of the free wall of the right ventricle is responsible for the small R. The deep broad S is transmitted now from the right ventricular cavity through the now resting free wall of the right ventricle. Now for the first time there is initial positivity of the left venticular cavity F2, due to early septal activation from right to left. This initial positivity is transmitted through the free wall of the resting left ventricle to record an R in G2. The S wave in the left ventricular cavity represents negativity due to late activation of the free wall of that chamber in a direction away from the cavity. This same activation is in a direction towards the G3 electrode and records the R1 in that lead.

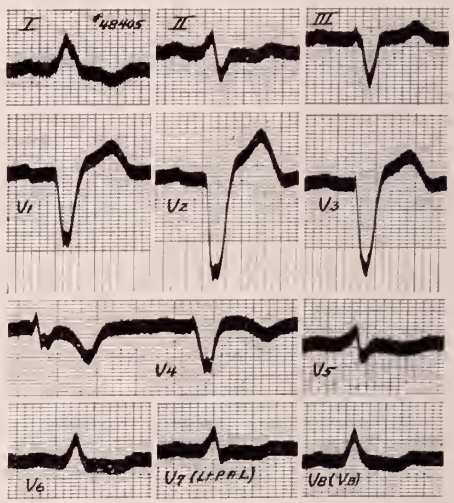


Figure 2

In the presence of an anterior infarct with right bundle branch block certain major changes are noticed. In lead E3 a Q replaces the small R as compared to lead E1. This change is due to the initial negativity of the left ventricular cavity which overcomes the earlier activation of the septum from left to right and results in the weakly positive potential as manifested by R in E1. It should be remembered that the precordial leads are not direct leads and thus record potential variations from much wider epicardial surface, in this particular instance part of the epicardial surface of the infarcted area of the left ventricle and the transmission of its initial negativity to the precordial leads. A second major change occurs in lead G3 consisting in a Q which also reflects initial negativity of the left ventricular cavity as transmitted through the underlying infarcted area.

In the presence of an anterior infarct in left bundle branch block the only change is noted in lead G4. In this lead no Q wave is seen as the infarcted area again reflects the initial cavity potential of the underlying left ventricle, which in the presence of this bundle branch block is

initially positive. It is for this reason that a diagnosis of anterior infarction in the presence of left bundle branch block cannot be determined by the precordial electrocardiogram.

An unusual tracing of anterior infarction in the presence of left bundle branch block is shown in figure 2. In lead V4 when a ventricular premature contraction occurred with a small QRS area, a sharp deep inversion of the T wave was disclosed. The electrocardiogram was taken about two months after the infarction.

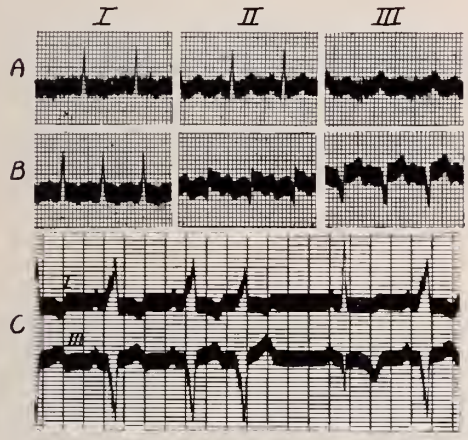


Figure 3

Figure 3 shows an example of posterior infarction obscured by a left bundle branch block except when an extrasystole occurred and was followed by a compensatory pause, whereupon the typical changes of infarction were revealed. Record A was made when the patient was complaining of anginal pain. Record B was made almost three years later and two days after symptoms of myocardial infarction. Record C shows leads I and III taken simultaneously one year later and shows the extrasystole.

In figure 4, the first tracing shows posterior infarction ten days after the attack. The precordial leads not shown here revealed only an inverted T in V6. The second tracing taken one week later shows an intraventricular block which was transient in nature and obscured the electrocardiographic evidence of the infarct. The subsequent records four years later show the block again present, and the precordial leads suggest a left bundle branch block. The findings of infarction in the standard leads are again obscured.

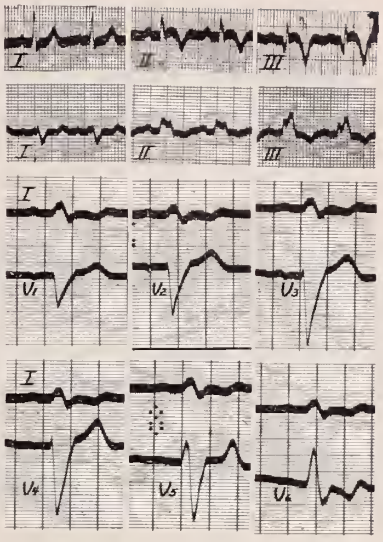


Figure 4

Anterior infarction complicated by right bundle branch block and arborization block is seen in figure 5. In this case the infarction occurred one year before the block. The Q in the precordial and standard lead I identifies the infarction. The prolonged QRS plus the late tall R's in V1, V2 and V3 identifies the right bundle branch block. The absence of the small R in V1 as normally seen in uncomplicated right bundle branch block is replaced by a Q in that lead and confirms the presence of the infarct. The late R and absence of S identify the arborization block.

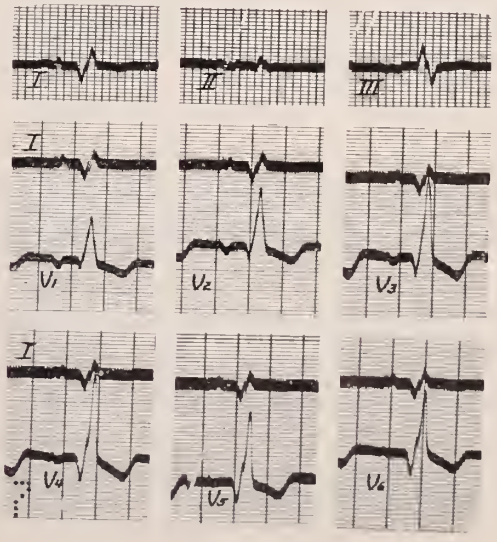


Figure 5

A most interesting tracing is seen in figure 6. Right bundle branch block is present with signs of posterior infarction in the limb leads and anteroseptal infarction in the precordial leads. The onset of the fresh anteroseptal infarction occurred 10 hours before the tracing was recorded.

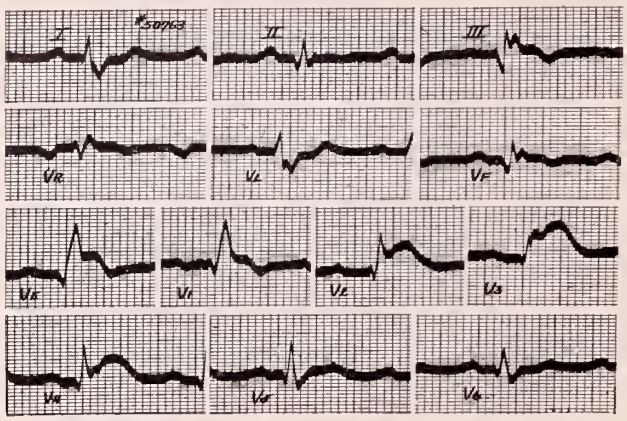


Figure 6

In figure 7 a good illustration is seen of the obscuring of the QRS of a recent posterior infarction when right bundle branch block occurred as manifested by the standard leads. A shows recent posterior infarction. B taken 11 days later shows infarction obscured by right bundle branch block. C taken 15 days later shows block no longer present and typical changes again seen.

In figure 8 in the first tracing there is evidence of posterolateral infarction. In the second tracing three days later signs of fresh infarction are present in leads II, III, Vf, V6 and V7 and right bundle branch block. In the third tracing 11 days later the more distinct QRS changes over the left precordium indicate extension of the infarcted area.

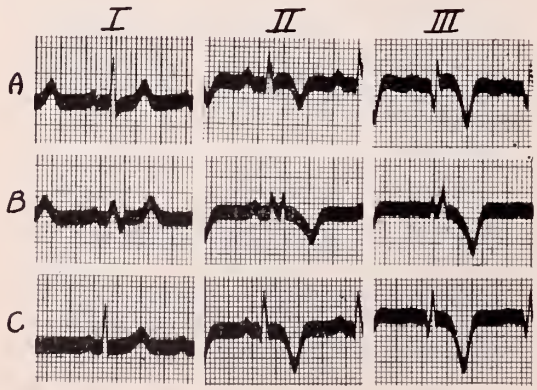


Figure 7

Summary

The complex electrocardiogram is discussed in reference to infarction in the presence of conduction defects and in reference to fresh infarctions superimposed on older infarctions. Several electrocardiographic illustrations of such conditions are presented. A review of the underlying electrophysiology responsible for such complex electrocardiograms is offered in diagram form.

The signs of anterior infarction complicated by right bundle branch block are usually absent in the standard leads and the unipolar extremity leads. The precordial leads, however, are diagnostic of the infarction. In posterior infarction in the presence of right bundle branch block diagnostic signs of the infarction are usually present in leads AVF, III and II.

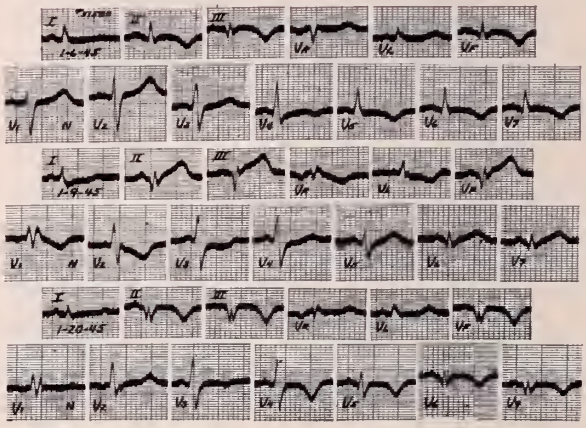


Figure 8

In the presence of left bundle branch block the electrocardiographic diagnosis of myocardial infarction can rarely be made. This difficulty is due to a failure of diagnostic changes to appear because of initial positivity of the left ventricular cavity potential which are resultant from the conduction defect.

The electrocardiographic illustrations are taken from the original collection of the late Dr. Frank N. Wilson, to whom I am indebted for permission to use them.

420 Lincoln Road.

ABSTRACTS OF MEDICAL ARTICLES

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 1018, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

The Journal of the American Medical Association is limiting its Current Medical Literature section. Thus, our main source of information on articles written by our members has been greatly curtailed.

Prolonged Drug Therapy in Peptic Ulcer. 1. An Evaluation of Banthine® as an Adjunct to Conventional Ulcer Therapy. By E. C. Texter Jr., M.D., C. W. Legerton Jr., M.D., Julian M. Ruffin, M.D., J. S. Atwater, M.D., David Cayer, M.D., F. D. Cheney, M.D., R. A. Jackson, M.D., B. G. Oren, M.D., and J. M. Rumball, M.D. South. M. J. 46:1062-1069 (Nov.) 1953.

A long range study was undertaken in an effort to answer four questions: Does the ulcer-bearing patient who is taking Banthine (methantheline bromide) daily in recommended doses fare materially better over a long period than those who are not taking the drug? Does he have fewer or less severe recurrences? Are complications less frequent? Can surgery be avoided? Banthine or atropine was administered to 292 patients in several localities: Atlanta, Ga., 71; Winston-Salem, N. C., 49; Dublin, Ga., 26; Fayetteville, N. C., 31; Miami 46; Coral Gables 9, and Durham, N. C., 60. Satisfactory data were obtained on 250 of these patients. The mean period of observation was 13 months, with a range of six to 24 months.

The questions were answered as follows: The ulcer patient fares materially better on conventional therapy supplemented by Banthine than on the same therapy with atropine. He will have significantly fewer or less severe recurrences. Complications cannot necessarily be prevented. The need for surgery cannot necessarily be avoided. It was concluded that in most patients with duodenal ulcer Banthine produces symptomatic improvement, which is inversely proportional to the clinical severity of the ulcer. The eventual course of peptic ulcer does not appear to be altered by the administration of Banthine. This drug should be used as an adjunct to conventional therapy, never as a substitute.

Management of Vesicourethral Dysfunction in Women. By Russell B. Carson, M.D. J. A. M. A. 153:1152-1155 (Nov. 28) 1953.

A review of the reasons for consultation of the last 1,000 women patients seen in private urologic practice is presented. In 52.9 per cent of these patients dysfunction of the lower part of the genitourinary tract was the primary pathologic process present. An explanation is offered for the frequent occurrences of chronic urethritis, called "sliding urethra" in this study. The management of some types of urethral and bladder dysfunction, notably urethral caruncle, cystitis, chronic cystitis, bladder neck contracture and diverticulum, is outlined. The anatomy and physiology of the vesicourethral tract are discussed with a view to clarifying the mechanism involved in the various dysfunctions.

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HOMER F. MARSH, Ph.D.



GEORGE T. HARRELL JR., M.D.



ROBERT T. SPICER, M.D.

Robert T. Spicer, M.D., Retiring Dean
University of Miami School of Medicine

Dr. Robert T. Spicer of Miami, first Dean of the University of Miami School of Medicine, was appointed to the deanship on Dec. 14, 1953. After serving with distinction in that office for nearly eight months, he resigned on Aug. 1, 1954, for health reasons, relinquishing the post to Associate Dean Marsh. Dr. Spicer reports that he has no immediate definite plans, but will continue to reside and to base his activities in Miami, where he and Mrs. Spicer have lived since June 1929.

Homer F. Marsh, Ph.D., Dean
University of Miami School of Medicine

A Hoosier by birth, Dr. Homer F. Marsh was born in Terre Haute, Ind., in 1909. He received his undergraduate degree from Indiana State Teachers College in 1930 and was awarded the degree of Master of Science in Bacteriology by Purdue University in 1932. From 1932 until 1934 he remained at Purdue, engaging in further graduate work and teaching on a part time basis. After four years spent as a diagnostic bacteriologist in a Cincinnati hospital and as a production bacteriologist with pharmaceutic firms, he resumed graduate work, and in 1941 Ohio State University granted him the degree of Doctor of Philosophy in Bacteriology. During his last year there, he held the rank of Instructor in the Department of Bacteriology.

In October 1941, Dr. Marsh joined the faculty of the University of Oklahoma School of Medicine as Assistant Professor of Bacteriology and in the next six years became Associate Professor, Professor, and finally Chairman of the Department. His research interests during this period concerned the intestinal bacteria, the mycotic diseases, and the Rh blood group antigens. In 1947, he became Associate Dean of the School of Medicine, continuing in that position until July 1952.

Dr. Marsh came to the University of Miami in August 1952 as Associate Dean of its embryonic medical school and had put together a nucleus of faculty in anatomy and biochemistry when the School of Medicine opened on Sept. 22, 1952, with its first class of 28 medical students. In December 1952 he became Acting Dean of the school and remained in that capacity until the appointment of Dr. Robert T. Spicer as Dean in December 1953, whereupon he resumed the status of Associate Dean.

On Aug. 1, 1954, Dr. Marsh was appointed Dean of the School of Medicine to succeed Dr. Spicer, whose resignation was tendered for reasons of health and became effective on that date.

George T. Harrell Jr., M.D., Dean
College of Medicine of the University of Florida

A native of the nation's Capital, Dr. George T. Harrell Jr. was born in Washington on June 16, 1908. He received the Bachelor of Arts degree in 1932 and the degree of Doctor of Medicine in 1936 from Duke University. Then he served as intern, assistant resident and resident in medicine at Duke Hospital and for two years was Instructor in Medicine at the Duke University School of Medicine. From 1941 through 1953 Dr. Harrell was associated with Bowman Gray School of Medicine of Wake Forest College, Winston-Salem, N. C., serving successively as Assistant Professor, Associate Professor and Professor of Medicine over a period of 10 years, the last seven of which he was Director of the Department of Internal Medicine. He also served concurrently for three years during this period as Associate Professor of Preventive Medicine. The last two years there, he was Research Professor of Medicine. On Jan. 1, 1954 he became Dean and Professor of Medicine of the College of Medicine of the University of Florida.

A member of numerous medical and scientific societies, Dr. Harrell has served many of them in official capacity. In 1953 he was president of the Southern Society for Clinical Research, and since 1951 he has been chairman of the Medical Advisory Panel of the Oak Ridge Institute of Nuclear Studies. He is a member of the Commission on Chronic Illness. A contributor to many medical journals and speaker of renown, he has lectured in practically every Southern state and in all sections of the country, having delivered such important national lectures as the Kellogg Lecture of 1953 and the Alpha Omega Alpha Lecture at Harvard.

Dean Harrell's research interests are in infectious diseases, in which he has made notable contributions through the study of alteration of fluid balance during infection by radioisotopic technics; antibiotic therapy with penicillin, streptomycin and Aureomycin; and the application of radioisotope technics to the study of physiologic changes in myxedema and other metabolic problems. He has held a number of important research grants, and he received the First Scientific Award at the 1953 meeting of the Southern Medical Association for his research work on the cellular changes of sodium and potassium in man. On invitation, he has presented the results of his research at the universities of Oxford, Padua, Naples, Liége, Leiden, Brussels, and London and also has addressed the International Physiologic Congress at Oxford and at Montreal.

Program for the University of Miami School of Medicine

In its two years of operation, the University of Miami School of Medicine has expanded its first year class to 65 students. Its full time faculty has increased to 28 members, and about 50 members of the Dade County Medical Association are members of the faculty on a voluntary basis. Foundations are being poured now for a new Outpatient Clinic Building on the grounds of the Jackson Memorial Hospital to provide adequate clinic teaching facilities for the school. Architects are drawing plans for a new Medical Sciences Building, also to be located at the Jackson Memorial Hospital, to replace the present temporary quarters of the basic science departments. Within two years, the entire medical school will be located at the Jackson Memorial Hospital, which will provide adequate clinical teaching material.

The clinical departments of instruction will be organized around a small nucleus of full time men with the practicing physicians of Dade County constituting the majority of the faculty in these areas.

It is the basic attitude of the administration of the medical school that the school has but one fundamental reason for being, namely, to train young men and women to take their places in the practice of general medicine. No attempt will be made in the undergraduate curriculum to stress the special areas of medicine although the students will be given sufficient basic training in those areas to permit them to continue with graduate work as desired. Ancillary activities will of course be developed as soon as possible.

It is a basic premise of the administration of the medical school that such an institution has two fundamental obligations to the people of Florida. It is an obligation to train the best possible physicians to give care to the citizens of Florida, and it is an obligation to encourage, in all possible manner, an adequate distribution of the school's graduates throughout the state. Development of a sound curriculum will accomplish the former need, and development of programs showing the advantages of locating in the smaller communities of the state will accomplish the latter.

Homer F. Marsh, Dean

Program for the College of Medicine of the University of Florida

Construction of the College of Medicine is under way at the University of Florida. The design of the physical plant and curriculum is based on an extensive study, supported by the Commonwealth Fund, of the needs of the state and the type of medical school which should be established.

The primary task of the College of Medicine is education. Medical students will be trained through a broad University-wide program of teaching, research and care of patients to apply scientific tools and methods to the practice of the art of medicine. The curriculum will emphasize all phases of health so that the future family physician will learn to work with members of other professions as a team. Many unusual features in the building emphasize that in medicine the student has embarked on a never ending process of self education. The intellectual tools and technics of study used throughout his professional life are introduced in the freshman year through an individual study cubicle.

Medical care is best given by the family physician in the local community, where the effect of illness in one member of the family on all of the others in the home environment is seen. Physicians throughout the state will serve as preceptors for senior students assigned to them to emphasize the practical application of theoretic training in the highly personal, confidential relationship between a doctor and his patient.

All members of the Florida Medical Association are cordially invited to visit the campus at Gainesville and discuss the plans for the College of Medicine. A room is being built for the use of any physician in the state who wishes to study or attend teaching exercises. A unique ambulant patient facility is planned as part of the teaching hospital — the second unit of the Health Center. Patients will be referred by their physicians. The Health Center has been planned to serve the entire State of Florida as an extension of the strong right arm of the doctor at home and to be a facility of which the profession can be justly proud.

George T. Harrell, Dean

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Florida Medical Association

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Making Doctors

> To study the phenomena of disease
> without books is to sail an
> uncharted sea, while to study
> books without patients is
> never to go to sea at all.
> Osler: Books and Men

In order to appreciate the pattern of training of a medical student, one must peer into the past and review the obligation owed today to traditions developed through centuries of man's struggle with disease. Obviously, this training deals first with the patient himself, as an individual, and second with the treatment of his disease, whatever it may be. The first of these objectives, the confidential relationship of an individual doctor with an individual patient, was clearly enunciated by Hippocrates two thousand years ago and has withstood the test of time, determining the pattern of medical ethics from that early day to the present.

The second objective, the training of the student in the treatment of disease, naturally has altered across the years with the changing concepts of disease and disease processes. Down through the centuries medicine, referred to only as the Art by Hippocrates and his successors up to modern times, has turned for help to magic, to astrology, to alchemy, to religion, and most recently to science. Today, these changes in alliance of medicine to contemporary philosophy are also manifest in the definite and not inconsiderable effect of the present social and economic change upon the teachers and the teaching of medicine.

What are the aims of medical education at the present time, and in what way are they being achieved? So great has been the impact of science upon medicine as to eclipse the art in recent decades. In the words of Sir Auckland Geddes, "So many come to the sick room thinking of themselves as men of science fighting disease and not as healers with a little knowledge helping nature to get a sick man well." Today the immediate trend is toward an appropriate synthesis of healer and scientist, and the highest type of medical training is accomplished through a threefold program of teaching, research and care of patients whereby the student learns to apply scientific tools and methods to the practice of the art of medicine. The many facets of the subject of medical education at the present time are aptly set forth in the address of Dr. Wilburt C. Davison, Dean of Duke University School of Medi-

cine, presented at the Eightieth Annual Meeting of the Florida Medical Association last April, which is published in this issue of The Journal.

Inherent in the practice of medicine as a profession are a desire and a responsibility to serve the people. In their statements appearing in the editorial section of this number of The Journal, Dean Marsh of the University of Miami School of Medicine and Dean Harrell of the College of Medicine of the University of Florida both emphasize that the purpose of Florida's two medical schools is to train doctors to serve adequately the needs of this state with its rapidly growing population. The keynote of these two major ventures is service for all sections of the state.

The present philosophy of medical education not only stresses service adequate to meet the needs of the people, but it also wisely does not overlook — in fact, it emphasizes — the broad concept of general education of the professional person. For that reason, Florida is fortunate to have each of its new medical schools an integral part of a university program, where the contributions of different phases of education can best be recognized and utilized. Education in the light of the total personality of its medical students will receive due attention in this state. Dr. Russell S. Poor recently expressed this aspect of professional training in these words: "If the possible contributions of general education to the acquisition of the tools of learning are overlooked, if the possible contributions of the humanities to aesthetic and cultural values are ignored, if the possible contributions of the social sciences to an understanding of community problems are not valued highly — if these and other possible contributions of different disciplines are not considered as vital and related elements in the education of a physician, the educational process is not complete. Moreover, the physician is neither so good a practitioner of medicine nor so effective a citizen as he could have been."[1]

Now that Florida is undertaking for the first time the training of her future physicians, the two medical schools are being developed at a propitious time to meet her growing needs. The magnitude of the task precludes faint heart and bespeaks warm support for the universities and the able educators who with enthusiasm and zeal are valiantly undertaking this vitally important mission.

1. Poor, R. S.: Planning Florida's Health Leadership: A Summary, Gainesville, University of Florida Press, 1954, p. 1.

Florida Benefits Under Hill-Burton Act

Senator Lister Hill, co-author of the Hill-Burton Act, which provides federal funds for the erection of hospitals on the basis of community need, reminded Floridians recently of the benefits already accruing to them from this source. The veteran Alabama solon, son of a rural surgeon, was the guest speaker at the tenth annual dinner commemorating the founding of the Florida Blue Cross, held in Jacksonville early in July.

Named for Lord Lister, the father of modern antiseptic surgery, this distinguished legislator pointed out that participation by the federal government in the building of state and municipal hospitals and other health facilities, coupled with the simultaneous extension of voluntary health insurance, has given pressure groups advocating socialized medicine a real setback. He was, however, quick to warn the 350 physicians and hospital officials in attendance that these proponents of compulsory federal health insurance, while temporarily checked, are by no means defeated. They will not be defeated, he said, until two problems, the availability of hospital facilities in areas in need of such facilities and the higher cost of medical care, have been solved.

"Within our day and almost within our generation, the hospital has evolved from a refuge for the dying to a necessity for the living," the Senator stated. "The revolution in medical practice and the evolution of the hospital from a refuge for the few to an institution recognized as essential to the lives and health of all of us have produced in the minds of the American people a new concept of medical care. We have lifted our sights both as to the quality of the medical care we expect and as to its availability."

He found in Florida an excellent example of how the philosophy of the Hill-Burton Act has worked. In this state, as in the nation as a whole, there were available at the beginning of the program only about one half the general hospital beds needed, and there was even greater lack of facilities for the care of mental patients and those with tuberculosis and chronic disease. With the financial aid and incentive from the act, Floridians promptly achieved an outstanding record in the building of hospitals and health facilities. "Beautiful new hospitals — modern in every detail — began to open their doors in community after community which had no hospital of any

kind before, providing the finest workshops for your doctors and making it possible for them to bring you the best in medical care," he declared. "The building of hospitals and health facilities in Florida under the program has been limited only by the amount of funds appropriated pursuant to the act. The new urge to build hospitals refused to recognize these limitations and you have gone beyond the program and built hospitals outside the program."

The responsibility for administering the Hill-Burton program in Florida is vested in the hospital division of the State Improvement Commission, established in August 1946, the same month that the Congress approved the Federal Hospital Survey and Construction Act. On May 8, 1948, nearly two years later, Florida had the distinction of dedicating the first Hill-Burton hospital in the United States, the Suwannee County Hospital in Live Oak, which was opened on Aug. 12, 1948.

During the last six years, 65 per cent of the 2,827 general hospital beds for acutely ill patients which have been constructed received assistance through the Hill-Burton program. In the same period, 6,856 beds of all categories were constructed, with 37 per cent receiving grant-in-aid funds. Ten of these beautiful new plants were pictured recently in the Journal of the American Medical Association.[1] Of 55 projects receiving Hill-Burton grants, 30 have been completed at a total cost of $29,581,362, including a federal contribution of $10,229,753, and have supplied 2,542 additional beds. At the present time 12 projects are under construction, and 13 others have been approved for participation in the program, but are not yet under construction.

As of May 1, 1954, the cost of Hill-Burton hospital and health center construction, completed or approved for participation, was $44,044,703, and of this amount 31 per cent was federal grant-in-aid funds. The state agency now has before it inquiries for further construction of projects estimated to cost $62,871,701, for which grant-in-aid funds amounting to about $24,091,022 are needed. The average cost per bed of construction in Florida, approximately $13,000, is slightly less than the average for the southeastern area of the United States. There has been the same percentage of construction of hospitals in the range of 25 to 49 beds as in the range of 100 to 299 beds.[1]

Hill-Burton aid has brought hospitals to Florida areas previously without facilities to render medical care, thereby drawing new doctors to these areas. The greatest relative financial assistance has gone to hospital areas of relatively poor economic status. The rapid growth in population poses a problem for Florida, shared only by two other states, for this growth is not fully reflected in the federal population figures required for computing bed need as well as the state's share of grant funds. Because of the continued urgent need for construction funds in the rural areas, Hill-Burton funds will not be used for Florida's rehabilitation hospital for alcoholics now being developed, nor for the proposed hospital to be operated in conjunction with the new medical school being established at the University of Florida in Gainesville. The facilities of the Jackson Memorial Hospital in Miami will be used for teaching purposes by the new University of Miami School of Medicine, now in its second year of operation.

Florida's rapid progress in providing hospital facilities where most needed should be highly gratifying to every citizen of the state. Senator Hill offered a timely reminder in the concluding words of his address: "As we bring the benefits of hospital and medical care to our people, we are building the health and strength of our people. We are building the strength of America. We are making America strong that we may keep America free."

1. Hospitals Built with Hill-Burton Aid, J. A. M. A. 155: 582-583 (June 5) 1954.

A Concrete Constructive Program of Public Relations

Emphasizing the positive, in medicine as elsewhere, gives the spirit a lift that is both constructive and exhilarating. The positive note in Florida medicine is well exemplified in the public relations program of the Florida Medical Association.

Not long ago every member of the Association received an attractive brochure containing an outline of the Association's Public Relations Program which was approved by the House of Delegates. On the inside of the front cover a message from Dr. Edward Jelks, Public Relations Liaison Member of the Board of Governors, emphasized the positive nature of this program, which rests primarily upon service to the public and has been developed through broadening the scope of many past activities and adding new projects based upon sound and proved public relations principles.

Dr. Jelks praised the county medical societies throughout the state for the outstanding progress they have made in the many phases of the public relations program through numerous activities of service to the public. He also urged each member to study the outline in the brochure with a view to taking inventory of local activites and further developing an active well rounded program for his county society.

In attractive form under five headings the brochure presents the salient features of the program. Careful perusal of this outline enables each member to familiarize himself with the many phases of this vitally important aspect of medicine today at the county society level.

The brochure also reminds the members that the Board of Governors, through its Public Relations Liaison Member, and the Association's Bureau of Public Relations with its staff and facilities are available to the component county societies in initiating and implementing local programs. Also, on the state level there is a Public Relations Advisory Committee composed of the Public Relations Committee chairmen of five component county societies. The advice and work of this Committee are of great value in formulating and implementing programs that will best meet the various public relations needs of component county societies and the Association's over-all program. General information and specific data pertaining to the individual phases of the program are always available from the Bureau of Public Relations at Association headquarters.

To enable each member to visualize and evaluate the activites of his county medical society the brochure has a convenient form on the inside of the back cover. Did you check it on your brochure, as requested? If not, check the reproduction presented here as a guide to progress in your county society's public relations program and then act upon the information gained to broaden the scope of the program.

DOES YOUR COUNTY MEDICAL SOCIETY'S PUBLIC RELATIONS PROGRAM INCLUDE . . .

Medical Care For All By	**Yes**	**No**
The guarantee of a physician's services to every citizen	[ ]	[ ]
An efficient emergency call service which has been publicized	[ ]	[ ]
Promoting the personal physician concept	[ ]	[ ]
An adequate indigent medical care program	[ ]	[ ]
Hospital facility expansion if needed	[ ]	[ ]
Physician placement in areas where needed	[ ]	[ ]
A program of rural health	[ ]	[ ]
An active grievance committee which has been publicized	[ ]	[ ]
Paying For Medical Care Through		
Promoting the discussion of fees between physician and patient	[ ]	[ ]
Promoting voluntary health insurance	[ ]	[ ]
Sponsoring a Budget for Health plan	[ ]	[ ]
Information and Education Through		
Medical Forums	[ ]	[ ]
Feature newspaper articles	[ ]	[ ]
Radio-TV programs, live or transcribed	[ ]	[ ]
An active speakers' bureau	[ ]	[ ]
Sponsoring of fair exhibits and displays	[ ]	[ ]
A Press-Radio-TV Code of Cooperation	[ ]	[ ]
Press-Radio-TV Conferences	[ ]	[ ]
Working With Others By		
Participation of the Woman's Auxiliary	[ ]	[ ]
Cooperation with allied groups	[ ]	[ ]
Cooperation with other professional groups	[ ]	[ ]
Physicians' participation in civic organizations	[ ]	[ ]
Physicians' participation in community projects	[ ]	[ ]
Liaison with organized labor	[ ]	[ ]
Coordination and planning with governmental and independent agencies	[ ]	[ ]
Medical Society's Unity Through		
Promoting active participation by all medical society members	[ ]	[ ]
Indoctrination of Members, Internes, Residents, Medical Students	[ ]	[ ]

Reinsurance Plan Shelved

On July 13, 1954, the House of Representatives by a vote of 238 to 134 recommitted to the Committee on Interstate and Foreign Commerce President Eisenhower's proposed bill for reinsurance of prepaid health plans. House Leader Halleck (Ind.) was quoted by the press as saying recommital would kill the measure. The President, however, in a press conference referred to the House rejection of the measure as merely a temporary setback and declared his intention to keep fighting for the program.

In the resulting political controversy the American Medical Association has been blamed by some newspapers for "defeat" of the bill. It did oppose the measure, but was by no means alone in its opposition. Most of the nation's insurance experts also opposed it. The one salient conclusion of the opposing group was that the bill, as considered by the Congress, would add nothing to the present rapidly expanding and successful health insurance field.

Shortly before the Congress took its action, the Board of Trustees of the American Medical Association reiterated its opposition to the bill. Said Dr. Walter B. Martin of Norfolk, Va., presi-

dent of the A. M. A.: "While the administration has repeatedly stated that the bill does not involve federal subsidies, it is our opinion that federal subsidization of the private insurance industry is an inevitable result."

The six principal reasons for A. M. A. opposition to the bill are:

1. The mechanism suggested will not accomplish the stated purposes of the bill: to promote the best possible medical care on reasonable terms.

2. The phenomenal progress of the health insurance industry makes federal intervention not only unnecessary but a dangerous intrusion into a successful area of private enterprise. Such intervention would not help and could hinder continued expansion of health insurance coverage.

3. 'Reinsurance' would not make health insurance more attractive to persons who can afford to pay premiums and have not done so. It would not make health insurance available to the indigent unless the government provides a subsidy for the purpose of selling insurance for less than the cost of servicing the contract.

4. The program, without subsidy, would not reduce the cost of insurance, nor would it make health insurance available to any additional groups or geographic area that voluntary insurers cannot reach.

5. Most insurance authorities agree that the extent of health insurance liability is such that a federal reinsurance program is absolutely unnecessary.

6. The measure would place extensive regulatory power in the Secretary of Health, Education and Welfare. The concentration and delegation of such authority and control over a vital branch of American industry in an Executive Department of the government without clear and convincing evidence of need cannot be justified.

Congressman Williams of Mississippi, in describing on the House floor what the reinsurance bill means, said: "I took my youngster out to the park about two months ago, and she saw them selling cotton candy, all pink and pretty and inviting. Naturally, she had to have some. That cotton candy was pretty. It tasted sweet and smelled sweet, but when she tried to bite into it she found nothing there. This bill is like that cotton candy, all air and no substance, but costly."

San Francisco A.M.A. Meeting

Since 1871 the American Medical Association has been meeting periodically in annual session in San Francisco. For the eighth time in 83 years its members gathered there the week of June 21-25, 1954, this time for the 103rd Annual Meeting, and some 100 Florida physicians returned from California's great metropolis with delightful recollections of a profitable and enjoyable occasion. The proceedings of the 1871 and 1894 meetings contain no record of attendance, but 2,307 physicians attended the third San Francisco meeting in 1915; 3,726 the fourth, in 1923; 6,034 the fifth, in 1938; 7,746 the sixth, in 1946; and 10,119 the seventh, in 1950. This yardstick of growth lends interest to the all time high record at the recent meeting when 12,063 physicians and 30,906 guests brought the official total to 42,969, exceeding by several hundred the total for the 1953 New York meeting.

In their excellent report appearing in this issue of The Journal, the able representatives of the Florida Medical Association, Dr. Louis M. Orr and Dr. Reuben B. Chrisman Jr., and Dr. Thomas H. Bates, alternate for Dr. Herbert L. Bryans, present the highlights of the organizational side of the activities of the San Francisco meeting. Almost 90 resolutions were placed before the House of Delegates for consideration, and this review of the action taken on important matters will be of particular interest to all Association members.

In contrast to the 21 sections in the Scientific Assembly today, back in 1871 the American Medical Association boasted four sections, namely, Practice of Medicine and Obstetrics, Materia Medica and Chemistry, Surgery and Anatomy, and Meteorology and Epidemics. At that time its library, housed in the Smithsonian Institution in Washington, D. C., consisted of 339 volumes, reprints, periodicals and monographs. The report of the treasurer at that first San Francisco meeting showed a cash balance on hand of $704.32.

The tremendous expansion and growth of this organization, however, have not changed the purpose for which it was founded more than a century ago. Across the years the central theme of the annual meetings has been to promote the science and the art of medicine and the betterment of the public health. Annually, this purpose is emphasized through scientific exhibits, of which there were 220 this year. Exhibits on cardiovascular surgery received particular acclaim, and

a new feature was the question and answer conference on cardiovascular diseases presented in cooperation with the American Heart Association. The exhibits on fractures and on fresh pathology were especially popular, as in former years.

A quiz corner sponsored by the editorial boards of the special journals published by the American Medical Association was another new feature which was timely and evoked interest. It served as a consultation center where members of these editorial boards representing various specialties answered questions from physicians and advised them with regard to the publication of material that they might have available. Also, medical writing by the general practitioner was the subject of one exhibit. Here it was pointed out that the general practitioner sees 85 per cent of sick persons, but nongeneral practitioners do 95 per cent of medical writing. A collection of reprints of articles published by general practitioners in various journals was presented.

Likewise of vital importance in emphasizing the association's purpose are the individual meetings of the 21 scientific sections, and at this meeting about 300 papers were presented on all aspects of medical practice. Legal medicine was one of the newer additions to the program which attracted excellent attendance.

Interest now turns to the forthcoming Clinical Meeting to be held in Miami, November 29 through December 2. Florida now has an opportunity to extend its hospitality to the medical profession of the nation as graciously as did California earlier in the year. The Association rests assured that under the leadership of Dr. Homer L. Pearson Jr., general chairman, Miami with unique distinction will extend as hearty a welcome and offer as rewarding an experience as did San Francisco.

Registration

Total registration of Association members at the 1954 A.M.A. annual meeting in San Francsico was 89. Members in attendance were:

ARCADIA: Charles H. Kirkpatrick. BOCA RATON: William G. O'Donnell. BRADENTON: Willett E. Wentzel. CANTONMENT: Stanley G. Childers. CLEARWATER: Harvey J. Howard. CORAL GABLES: Jack Q. Cleveland, F. E. Kitchens, Joseph R. Morrow, Frederick P. Poppe, Louis C. Skinner Jr. DANIA: Fred E. Brammer. FORT LAUDERDALE: Burns A. Dobbins Jr., Garland M. Johnson, Richard A. Mills, Francis D. Pierce, George T. F. Rahilly. GREEN COVE SPRINGS: Edwin H. Brown. HOLLYWOOD: Louis J. Novak, Randall W. Snow. JACKSONVILLE: Sullivan G. Bedell, Lee E. Bransford Jr., Silas M. Copeland, Wm. S. Manning, John H. Mitchell.

LAKE CITY: Thomas H. Bates. LAKELAND: S. Allen Clark, Louis J. Polskin. MIAMI: Reuben B. Chrisman Jr., Milton M. Coplan, Carl H. Davis, Edward F. Fox, R. Spencer Howell, Paul S. Jarrett, George D. Lilly, James K. McShane Jr., Donald F. Marion, Benjamin G. Oren, Homer L. Pearson Jr., Max Pepper, William C. Phillips, Gerard Raap, John R. Ramey, Donald G. Stannus, Richard F. Stover, Herbert W. Virgin Jr. MIAMI BEACH: Bernhard Baer, Theodore M. Berman, Irvin M. Greene, Walter T. Hotchkiss, Maurice Kovnat, Alexander Libow, Cayetano Panettiere, Randolph Shevach, Nicholas A. Tierney.

MIAMI SPRINGS: Estella G. Norman. OCALA: Hugh H. Barfield. ORLANDO: Clarence Bernstein, L. Paul Foster, Lewis L. Kline, Morris H. R. Lukens, Pleasant L. Moon, Louis M. Orr, Robert W. Young. PALM BEACH: Burton F. Barney. PATRICK A. F. B.: James T. Hardy. PENSACOLA: Wilton E. Tugwell. ST. AUGUSTINE: Vernon L. Lockwood. ST. PETERSBURG: Dean W. Hart, Peter B. Kersker, James K. McCorkle, Robert J. Needles, Benjamin H. Sullivan. SARASOTA: John M. Butcher, Joseph Halton, Andrew J. Jesacher. SOUTH MIAMI: Franklyn E. Verdon. TALLAHASSEE: Benjamin A. Wilkinson. TAMPA: Frank S. Adamo, James N. Patterson, Richard C. Rodgers, Burdette Smith, Alvard L. Stone. VERO BEACH: Vernon L. Fromang. WEST PALM BEACH: V. Marklin Johnson, Theodore Norley, S. Richard Ombres, Cecil M. Peek.

CHAMBLEE, GA.: Edward E. Cava. ALEXANDRIA, LA.: Thomas C. Black.

1954 MEDICAL DISTRICT MEETINGS

"A" Marianna	October 11
"B" Sanford	October 13
"C" Sarasota	October 15
"D" Vero Beach	October 14

Report of Delegates to the American Medical Association 103rd Annual Meeting, June 21-25, 1954, San Francisco

The Florida Medical Association was represented at the 103rd Annual Meeting of the American Medical Association by its delegates, Dr. Louis M. Orr and Dr. Reuben B. Chrisman Jr., and Dr. Thomas H. Bates, alternate for Dr. Herbert L. Bryans. In addition, Mr. Ernest R. Gibson, Managing Director, and Mr. W. Harold Parham, Supervisor of the Bureau of Public Relations, were in attendance, as was Mr. John C. Lee, Executive Secretary of the Dade County Medical Association.

The final registration total for the San Francisco meeting was 42,969, made up of 12,063 physicians and 30,906 guests including nurses, medical students, exhibitors and wives and families of physicians. This exceeded the record-smashing attendance at the New York meeting of 1953 where the total registration reached an all time high of 42,144. There were 101 Florida physicians registered, many of whom were accompanied by members of their families.

Florida's representatives received considerable notice and achieved an excellent record for their activities. Dr. Orr's report for the Council on Medical Service received high praise. It was unanimously approved, as was his special resolution condemning the present practice of establishing service connection for veterans' disabilities by legislative fiat. Dr. Chrisman headed the Reference Committee dealing with all resolutions or proposed amendments to the Constitution and By-Laws. A number of changes were proposed and, because of the efficient manner in which he handled the Committee, he received considerable praise. Dr. Homer L. Pearson Jr., a member of the Judicial Council, was elected the new Chairman of that body, succeeding Dr. Edward F. Cunniffe of New York who served as Council Chairman for many years.

Fee splitting, osteopathy, closed panel medical care plans, veterans' medical care and the training of foreign medical school graduates were among the major subjects of discussion and action during the sessions of the House of Delegates.

Named as president-elect for the coming year was Dr. Elmer Hess of Erie, Pa., who, until his election, was serving as a member of the House of Delegates and as Chairman of the Council on Medical Service. Dr. Hess will become president of the American Medical Association at the June 1955 meeting in Atlantic City, succeeding Dr. Walter B. Martin, of Norfolk, Va. Dr. Martin took office at the Tuesday evening inaugural session in San Francisco's Palace Hotel.

The House of Delegates voted the 1954 Distinguished Service Award of the American Medical Association to Dr. William Wayne Babcock of Philadelphia for his outstanding contributions to medicine and humanity. Dr. Babcock, who was professor of surgery and clinical surgery at Temple University School of Medicine from 1903 to 1944, received the award from Dr. Martin at the Tuesday evening inaugural ceremony.

Fee Splitting

The House adopted a supplementary report of the Reference Committee on Miscellaneous Business which recommended acceptance of a Judicial Council report on the subject of billing and made the additional recommendation "that the House of Delegates resolve that it firmly opposes fee splitting, rebating or payment of commissions in any guise whatsoever and that it further opposes any mechanism that encourages this practice."

Osteopathy and Medicine

Four resolutions dealing with the osteopathic problem were considered. The House accepted a recommendation by the Reference Committee on Medical Education and Hospitals and adopted a Supplementary Report of the Board of Trustees on a Report of the Committee for the study of Relations Between Osteopathy and Medicine, which recommended (1) that direct on-campus observation and study of osteopathic schools be made and (2) that no action be taken on the report at this time and that final action be deferred until December 1954. It further recommended that the Committee be continued until December 1954, in order to be available to evaluate education in schools of osteopathy should the house of delegates of the American Osteopathic Association act favorably upon the recommendation of its Conference Committee.

Closed Panel Plans

The much publicized New York resolution, calling for several changes in the Principles of Medical Ethics relative to participation in closed panel medical care plans, was considered by the Reference Committee on Miscellaneous Business. That Committee made the following recommen-

dations, "since this will require clarification and interpretation of the Principles of Medical Ethics in relation to prepaid medical care plans and as set forth in the bylaws, the Judicial Council has jurisdiction on all questions of medical ethics.

"Therefore, your reference committee recommends that the House of Delegates request the Judicial Council to . . . investigate the relations of physicians to prepaid medical care plans and render such interpretations of the Principles of Medical Ethics as the Council deems necessary, and report to the House of Delegates not later than the next annual meeting of the Association."

Foreign Medical Graduates

Three resolutions and a Board of Trustees supplementary report were submitted to the House regarding the evaluation of foreign medical school graduates, a subject which attracted major interest earlier this year at the annual Congress on Medical Education and Licensure in Chicago.

The Reference Committee on Medical Education and Hospitals spent much of its time listening to the ideas and proposals of various state medical societies, state licensing boards, members of the Council on Medical Education and Hospitals and others. The reference committee recommended that "the intent and aims of this Supplementary Report and the three resolutions can best be met by referring the entire problem to the Council on Medical Education and Hospitals for further study. It is recommended that the Council report at the Interim Session in 1954 regarding the progress relative to this study."

Seal of Acceptance

The Council on Medical Service presented a supplementary report outlining the difficulties encountered in conducting the Seal of Acceptance program, and recommending discontinuance of the Seal of Acceptance for voluntary health insurance plans. The House adopted the Council report, thus terminating the Seal of Acceptance program for voluntary health insurance plans.

Registration of Hospitals

The House also approved a Board of Trustees report calling for discontinuation of the registration of hospitals by the Council on Medical Education and Hospitals and suggesting that the Joint Commission on the Accreditation of Hospitals be requested to undertake the registration of hospitals in addition to its present accreditation activities.

Miscellaneous

Among a wide variety of other actions the House also:

Voted to continue the holding of the annual Clinical Meetings;

Approved the establishment of a program of Medical Military Scholarships with appropriate safeguards limiting the number of students involved;

Approved the extension, on a voluntary basis, of the Medical Education for National Defense program which currently is in operation in five medical schools as a pilot study, and

Authorized the Council on Scientific Assembly to conduct a thorough study of the use of tape recordings of the material presented at meetings of the Council, and asked for a report at the December meeting.

The Reference Committee on Medical Education and Hospitals did not approve the resolution from Florida (Pinellas County), which sought to limit the activities of the Board for accrediting hospitals.

Opening Session

Highlights of the opening House session on Monday were selection of Dr. Babcock as recipient of the Distinguished Service Award and the addresses by Dr. Edward J. McCormick of Toledo, then president of the Association, and Dr. Martin, then president-elect.

Dr. McCormick called upon the medical profession to take the guesswork out of medical costs by adopting average fee schedules on an area or regional basis. The Reference Committee on Reports of Officers later suggested that the Board of Trustees make a study of such programs where they already are in operation, and the House approved.

Dr. Martin, in his opening session address, declared that the most urgent problem before the medical profession is that of financing hospital services to make them more generally accessible. In his presidential inaugural address, Dr. Martin said that physicians are duty-bound to keep themselves informed on public matters affecting the medical welfare of the people, and he also urged doctors to "reach back farther than the disease" in treating their patients.

Special Citations

Two special citations were presented by the Association during the San Francisco meeting.

During the presidential inauguration ceremony Dr. McCormick presented an award to a fellow Toledoan, Dr. Nicholas P. Dallis, for his outstanding health educational service as the writing member of the team that produces the illustrated feature, "Rex Morgan, M.D." At the closing House session on Thursday, Dr. Martin presented a special citation to Smith, Kline and French Laboratories of Philadelphia for "pioneering use of television in bettering the health of the nation." The plaque was accepted for the Company by Mr. Francis Boyer, President.

The closing session also brought the announcement that the California Medical Association had presented a check for $100,000 to the American Medical Education Foundation.

Election of Officers

The election at the closing session brought the following results, in addition to the selection of Dr. Hess as president-elect, whose nomination was seconded by Dr. Orr:

Dr. Clark Bailey of Harlan, Ky., was named vice president.

Dr. David B. Allman of Atlantic City and Dr. F. J. L. Blasingame of Wharton, Tex., were re-elected to their positions on the Board of Trustees.

Also re-elected were Dr. George F. Lull of Chicago, Secretary, whose nomination was seconded by Dr. Bates; Dr. J. J. Moore of Chicago, Treasurer; Dr. James R. Reuling of Bayside, N. Y., Speaker of the House of Delegates, and Dr. Vincent Askey of Los Angeles, Vice Speaker.

The House of Delegates also chose New York City as the place for the 1957 annual meeting, San Francisco for 1958 and Atlantic City for 1959. Previously selected were Atlantic City for 1955 and Chicago for 1956. The dates of next year's meeting in Atlantic City are June 6-10.

The Clinical Session for 1954 will be in Miami, November 29-30, December 1-2.

The 1955 Clinical Session will be in Seattle, while that of 1956 goes to Boston.

No report of Florida's participation in the activities in the 103rd Annual Meeting of the American Medical Association would be complete without giving due praise and credit to the activities of Mr. Gibson, Mr. Parham and Mr. Lee, all of whom were most helpful to your delegates. It was noticed that the lay representatives of other state medical associations were frequently seen seeking out these gentlemen in an effort to learn more about the Florida Medical Association and the work of the Dade County Medical Association in preparation for the 1954 Clinical Session of the American Medical Association, which will be held in Miami November 29-30, December 1-2. We can well be proud of these fine gentlemen.

Respectfully submitted,

Louis M. Orr
Reuben B. Chrisman Jr.
Thomas H. Bates

Southeastern States Cancer Seminar Miami, Dec. 2-4, 1954

The Southeastern States Cancer Seminar will be held this year at the McAllister Hotel in Miami immediately following the Clinical Session of the American Medical Association. The dates for this seventh annual meeting are December 2, 3 and 4. There should be a record attendance since many physicians attending the Clinical Session will undoubtedly wish to remain over for the Cancer Seminar. The Seminar is sponsored by the American Cancer Society, Florida Division, the Florida State Board of Health and the Dade County Medical Association.

The speakers and the subjects they will discuss are: Dr. William H. Baker, Boston, "The Role of Hormones in Breast Cancer;" Dr. J. A. del Regato, Colorado Springs, Colo., "The Role of Radiotherapy in the Treatment of Cancer of the Larynx" and "The Treatment of Cancer of the Lower Lip;" Dr. Charles L. Martin, Dallas, Texas, "The Treatment of Cancer of the Fundus of the Uterus;" Dr. Joe Meigs, Boston, "The Surgical Treatment of Cancer of the Cervix;" Dr. J. Elliot Scarborough, Emory, Ga., probably discussing cancer of the larynx; Dr. Danley P. Slaughter, Chicago, "The Surgical Treatment of Cancer of the Oral Cavity;" Dr. J. Urban, New York City, "Diagnosis and Surgical Management of Breast Cancer;" Dr. Owen H. Wangensteen, Minneapolis, "Cancer of the Stomach;" Dr. Willet Whitmore, New York City, "Diagnosis and Treatment of Testicular Neoplasms;" Dr. Alton Ochsner, New Orleans, probably discussing cancer of the lung; Dr. Richard Cattell, Boston, "Malignancy of the Colon and Rectum;" and Dr. Elson B. Helwig, Washington, D. C., "The Pathology of Carcinoma of the Cervix."

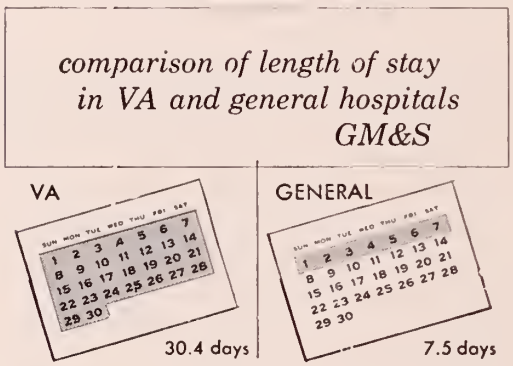
Florida Academy of General Practice Scientific Assembly October 17-18

The Fifth Annual Scientific Assembly of the Florida Academy of General Practice will convene at the San Juan Hotel in Orlando on Sunday, Oct. 17, 1954, at 1 p.m. and will continue through Monday, October 18. The excellent program, while planned primarily for general practitioners, should have wide appeal and is open to all physicians of the state, whatever their specialty. There is no registration fee. Some 30 leading drug and surgical firms will have exhibits. The Orange County Chapter of the Academy is sponsoring the meeting, an important feature of which will be the banquet at 8 p.m. on Sunday night.

Among the distinguished guest speakers are the Deans of Florida's medical schools, who will explain what the general practitioner should expect of and can contribute to medical education in Florida. The lecturers are: Dr. George T. Harrell Jr., Dean and Professor of Medicine, College of Medicine, University of Florida, Gainesville; former Dean Robert T. Spicer, University of Miami School of Medicine, Miami; Dr. Jack F. Schaber, Cardiologist, Orlando; Dr. Robert W. Curry, Radiologist, Orange Memorial Hospital, Orlando; Dr. Joseph B. Miller, Pediatrician, Mobile, Ala.; Dr. Fred Mathers, Chief of Medicine, Orange Memorial Hospital, Orlando; Dr. W. Ansell Derrick, Pathologist, Orange Memorial Hospital, Orlando; Dr. Robert P. Walton, Professor of Pharmacology, Medical College of South Carolina, Charleston, S. C., and author of the National Board questions; Dr. Sullivan G. Bedell, Psychiatrist, Jacksonville; Dr. Herbert A. King, Chief of the Medical Service, Halifax District Hospital, Daytona Beach; Dr. John E. Peterson, Professor of Medicine, College of Medical Evangelists, Los Angeles, Calif.; Dr. Milton S. Saslaw, Director of Medical Research, National Children's Cardiac Hospital, Miami; Dr. Francis H. Cole, Chief of the Surgical Service, West Tennessee Hospital of Chest Diseases, Memphis, Tenn.; Dr. Jack Glassman, former Professor of Surgery, Cook County Hospital Postgraduate School, Chicago; and Dr. Hawley H. Seiler, Chief of Thoracic Surgery, Southwest Florida Tuberculosis Hospital and Tampa Municipal Hospital, Tampa.

The program for the two day meeting appears on the opposite page.

In Viewing the VA Medical Program . . .



General medical and surgical patients in VA hospitals are confined four times longer than in non-federal hospitals. VA hospitals admit patients for examination, diagnosis, and treatment, much of which is normally undertaken outside civilian hospitals. Also, VA patients often remain hospitalized throughout the entire medical treatment period, whereas non-VA patients are usually treated at home during their convalescence. This is a major factor in the tremendous cost of the VA medical program.

L. Paul Foster, M.D., Editor
Florida Newsletter
Florida Academy of General Practice
1221 North Orange Avenue
Orlando, Florida

I plan to attend the Fifth Annual Scientific Assembly of the Florida Academy of General Practice at the San Juan Hotel in Orlando, October 17-18, 1954.

....., M.D.

PROGRAM
FIFTH ANNUAL SCIENTIFIC ASSEMBLY
FLORIDA ACADEMY OF GENERAL PRACTICE
SAN JUAN HOTEL, ORLANDO

SUNDAY, OCTOBER 17

12:00- 1:00	Registration and Exhibits	
1:00- 2:00	Welcome to the Assembly Dr. Leonard L. Weil, President, Florida Academy of General Practice Dr. Duncan T. McEwan, President, Florida Medical Association	
	"Postgraduate Education of the Family Doctor"	Dr. Spicer
2:00 -2:30	"Advances in Postoperative Care"	Dr. Glassman
2:30 -3:00	"Problems in Diagnosis of Thyroid Disease"	Dr. Peterson
3:00 -3:30	Recess for Exhibits	
3:30 -4:00	"Present Day Tuberculosis Therapy"	Dr. Séiler
4:00- 4:30	"Pitfalls in Diagnosis of Lung Diseases"	Dr. Cole
4:30 -5:00	"Use of Aerosols in Respiratory Diseases"	Dr. Miller
8:00	Banquet	

MONDAY, OCTOBER 18

8:30 -9:00	Registration and Exhibits	
9:00- 9:30	"Congenital and Rheumatic Heart Disease in Children"	Dr. Saslaw
9:30-10:00	"Diagnosis and Treatment of Cardiac Emergencies"	Dr. Schaber
10:00-10:30	"Recent Views of Drugs Used in Heart Dysfunction"	Dr. Walton
10:30-11:00	Recess for Exhibits	
11:00-11:30	"Psychotic Reactions in the Geriatric Patient"	Dr. Bedell
11:30-12:00	"Medical Emergencies"	Dr. Peterson
12:00- 1:00	Luncheon	
1:00- 1:30	"The Diagnosis and Treatment of Common Hematological Problems"	Dr. King
1:30- 2:00	"Radioactive Isotopes"	Dr. Curry
2:00- 2:30	"Chemotherapy in Malignant Diseases"	Dr. Mathers
2:30- 3:00	Recess for Exhibits	
3:00- 4:00	"The Place of the General Practitioner in Medical Education"	Dr. Harrell
4:00- 5:00	Clinicopathologic Conference	Dr. Derrick
5:00- 5:30	"Cholecystitis"	Dr. Glassman

Course in Electrocardiography National Children's Cardiac Hospital Miami, Sept. 20-25, 1954

"Modern Concepts of Electrocardiography" is the title of a course to be conducted by Dr. Demetrio Sodi-Pallares, head of the Department of Electrocardiography, Instituto Nacional de Cardiologia, Mexico, at the National Children's Cardiac Hospital in Miami this month. The course will open on Monday, September 20, and will continue through Friday, September 25, from 9 a.m. to 1 p.m. in the hospital's auditorium.

The program follows:

1. Electrophysiology
   (1) Theory of the dipole
   (2) Cellular polarization and reversed polarization
   (3) Experiments of Cole and Curtis
   (4) Unipolar and bipolar leads
   (5) Electrical field of the heart
2. Activation of the Normal Heart
   (1) Cardiac vectors
   (2) Auricular activation
   (3) Activation of the interventricular septum
   (4) Activation of the free ventricular walls
3. Auricular and Ventricular Enlargement
   (1) Different types of right and left ventricular enlargement
   (2) Mechanism of production of the electrocardiographic changes
4. Bundle Branch Block
   (1) Mechanism of production of the electrocardiographic changes
   (2) Different degrees of bundle branch block; its clinical significance
   (3) Bundle branch block versus focal block
   (4) Bundle branch block versus ventricular aberrant response
5. Electrocardiographic Changes in Coronary Blood Flow Disturbances
   (1) Muscle injury
   (2) Ischemic muscle
   (3) Dead muscle
   (4) Localization of myocardial infarction
   (5) Evolution of myocardial infarction
6. Electrocardiographic Patterns in Congenital Heart Disease
   Wolff-Parkinson-White Syndrome

Dr. Sodi-Pallares urges participants to bring in all of their unusual electrocardiograms for his evaluation and general discussion. Sessions will be held informally, and questions will be welcomed.

The cost of the course is $20. Since attendance is limited, it is suggested that all those interested apply at once, sending their check payable to the National Children's Cardiac Hospital, 4250 West Flagler St., Miami 34.

Tri-State Obstetric Seminar

The Tri-State Obstetric Seminar sponsored locally by the Maternal Welfare Committee of the Florida Medical Association and the Bureau of Maternal and Child Health of the Florida State Board of Health will be held again in the Daytona Plaza Hotel in Daytona Beach on September 13, 14 and 15. This Seminar now in its fourth year is becoming increasingly popular and will feature nationally known figures in the fields of obstetrics and pediatrics. The first day has been designated as Pediatric Day. The remaining days will be devoted to problems of particular interest to obstetricians and general practitioners. There is no registration fee and those attending should make their own hotel reservations.

Graduate Medical Education

The Twenty-Second Annual Graduate Short Course for doctors of medicine was held at the George Washington Hotel in Jacksonville July 12-16, 1954. The total paid registration was slightly over 10 per cent greater than last year. The interest manifested by those in attendance evidenced the type of lectures given. The series of lectures was planned primarily for the general practitioner, but constituted an excellent review and in addition presented the latest developments in medicine and surgery. Though many who attended expressed regret that the Short Course had to be held three weeks later than usual, it could not be avoided because of the annual meeting of the American Medical Association the last week in June. If a similar conflict does not occur next

year, this course will be held the last week in June as has been the custom since the beginning of the Short Course.

The Committee on Medical Postgraduate Course was particularly pleased to have the lectures on medicine given by Dr. George T. Harrell Jr., Dean and Professor of Medicine of the College of Medicine of the University of Florida. The reception given for Dr. and Mrs. Harrell at the cocktail hour on Wednesday, July 14, was well attended and afforded many Florida physicians the opportunity of meeting Dr. Harrell.

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The program for the second annual meeting of the Florida Clinical Diabetes Association in Orlando on October 21 and 22 was published in the August issue of The Journal. Guest lecturers, who are well known to many physicians of Florida, are Dr. H. B. Mulholland and Dr. Joseph T. Beardwood Jr. Any member of the Florida Medical Association, after paying a small registration fee, is eligible to attend the two day session without the necessity of joining the Diabetes Association.

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Plans for the course in Hematology, to be held in Jacksonville at the George Washington Hotel on November 18-20, have been completed. The detailed program will be published in The Journal. Programs will also be mailed to all physicians in Florida. The faculty will consist of Dr. William Dameshek, Director, Blood Research Laboratory, New England Center Hospital, Boston, Dr. Z. Komninos, Boston, his assistant, and Dr. James N. Patterson, Tampa. Only certified laboratory technicians or those presenting special requests from hospitals, private physicians or Boards of Health will be admitted to this course. The registration fee for physicians is $25 and for technicians $15. Advance registrations are requested.

OTHERS ARE SAYING

"M.D." — Not "Dr."

In these years when more and more individuals are earning degrees of Doctor of Chiropractic, Doctor of Osteopathy, Doctor of Philosophy, Doctor of Divinity, Doctor of Dental Surgery and Doctor of Medicine — not to mention the dozens of unearned honorary doctorates — the term "Doctor" or "Dr." is fast losing its meaning and significance. The medical profession must retain its identity and individuality, but cannot unless physicians themselves discontinue using the term "Doctor" whenever and wherever possible.

Physicians, upon graduation, are awarded the degree which is officially abbreviated "M.D." Let's remember that we are M.D.'s and let's use our degree to identify ourselves whenever our names appear in print or in writing. On professional cards, signs on office doors and windows, stationery, announcements, prescription blanks, yes, everywhere, have your name printed with the M.D.; sign your name with the M.D. People will then know that you are a physician, not a Ph.D., anything-else-D., or what have you.

Remember, also, to say "physician" or "surgeon" whenever possible in conversation, and you will be surprised how seldom it is necessary to say "Doctor." Our prestige will be enhanced as members of the medical profession if we will follow these suggestions.

—Contributed From Montana.
—*Rocky Mountain Medical Journal, May 1954*

R, E, and S

By Basil E. Barton, M.D., President

(The Norfolk District of the Massachusetts Medical Society)

It has become almost a cliche to compare medicine to a three-legged stool, which cannot stand unless all the legs are intact. The legs are called *Research, Education,* and *Service.* The first, being the most dramatic, receives the bulk of philanthropy. The second, in the opinion of the medical school deans, suffers correspondingly. The third is said to be not as good as it might be because practitioners are slow in giving their

patients the Service which Research and Education have made available. In short everyone is dissatisfied.

It was a pleasant surprise, therefore, to run across a second trilogy which bears the initials R, E, and S, but which differs from the other in being a sure-fire formula for happiness. It appears in a small, out-of-print book titled, of all things, "Talks to Freshman Girls" and written by Helen Brown for Vassar students. By thinking back over recent months one will see that it could have been as valuable a motto for a medical society as for a freshman girl. The R is for *Religion,* which for our purpose means the Golden Rule. E is again for *Education,* which in Society meetings is often gained the hard way. S is for a *Sense of Humor,* lack of which can make one look not a little ridiculous.

It will be a lot easier this year if we do unto others as we would be done by, having first tried to educate ourselves to the other person's point of view, and finally take seriously our jobs but not ourselves.

—*Norfolk Medical News, May 1954*

En Route

In a drive just completed to the West Coast, we were interested in conversations which we overheard.

At a restaurant in Arizona we were intrigued by two men whom we would judge to be in their forties — rather small of stature, quick, alert — of the terrier type. They attacked medicine and each incited and excited the other. They finally came to the conclusion that a doctor of medicine had to, at all times, respond at once to calls and that he should not be allowed to exercise his judgment as to the urgency of the calls or to take into account his own commitments or his own physical state. They left the restaurant in self-worked-up high dudgeon, bristling with indignation and ready to set upon and tree any hapless doctor who might come by.

We were interested in signs on homes advertising osteopath, chiropractor, and Swedish massage (apparently they do not dare use the word masseur), and at one home we saw the sign, "Herbalist." We inferred that someone was advertising himself as proficient in the medical use of herbs. We have never seen the word before. Maybe this marks the birth of a new cult — something to revivify and formalize what the old styled Indian doctors did.

But, never did we hear the cults berated as to responding to calls. Maybe they always respond because they are not overworked. It is our contention that the public has not been trained to a hostile attitude toward the cults — whereas they have for twenty years been bitterly conditioned against us — government press, franking privileges and injunctions against our own efforts to fight for our own rights. Why? Not because we are or have been bad — but because state medicine would be the keystone of the arch of a socialized state.

Numerous conversations overheard along the way brought us startlingly face to face with the fact that this hostile attitude is not limited to one section of the country but is wide-spread over the nation. It is here — whether it is our fault or not. We should do something about it. At the risk of being repetitious we would say that all doctors should begin enlightening their patients and other friends before an irreparable cleavage takes place.

F. T. H'Doubler, M.D.
—*Missouri Medicine, May 1954*

BIRTHS AND DEATHS

Births

Dr. and Mrs. Matthew A. Larkin of Miami announce the birth of a daughter, Catherine Ruth, on July 10, 1954.

Dr. and Mrs. J. K. David Jr. of Jacksonville announce the birth of a daughter, Barbara Najibah, on July 13, 1954.

Dr. and Mrs. Clyde M. Collins of Jacksonville announce the birth of a son, Clyde Mabry Jr., on July 16, 1954.

Deaths — Members

Lowe, Eugene C., Miami ..... July 2, 1954
Miller, George E., St. Petersburg ..... July 14, 1954

Deaths — Other Doctors

Davis, James D. (Col.), Tampa ..... June 6, 1954
Robles, Charles W., Tampa ..... June 18, 1954
Teagarden, Elmer J., Apopka ..... July 20, 1954

Medical Officers Returned

Dr. Charles K. Donegan, who entered military service on May 15, 1953, was released from active duty on June 13, 1954, with the rank of lieutenant commander, U. S. Navy. His address is 501 11th St., North, St. Petersburg.

SEE YOU IN MIAMI . . .

Eighth A.M.A. Clinical Session

November 29-December 2, 1954

The 8th A.M.A. Clinical Meeting in Miami will feature a related, balanced program of lectures and clinical conferences. Attention will be focused upon the diseases and conditions most frequently met by the General Practitioner.

Registration will begin at 8:30 a.m., Monday, November 29. The meeting will close each evening at 5:30 p.m., and Thursday, December 2, at noon. The morning and afternoon programs will consist of general meetings, clinical conferences and coordinated sessions. The main subjects on the program are: Neurology and Psychiatry, Arthritis, Dermatology, Gastrointestinal Diseases, Pediatrics, Obstetrics and Gynecology, Pulmonary Diseases, Orthopedics, Surgery.

Plan now for your attendance at this important meeting. There will be ample opportunity for discussion of your problems with demonstrators in Scientific Exhibits, which amplify new treatments and technics. America's leading firms will be represented in the Technical Exhibits to present modern and efficient equipment to better supply the General Practitioner.

STATE NEWS ITEMS

The largest group of physicians ever to seek admittance to practice medicine in Florida took examinations before the Florida State Board of Medical Examiners in Jacksonville, June 27-29, 1954. Dr. Homer L. Pearson Jr. of Miami, secretary of the board, said that 358 took the examination at that time; the largest previous number was 280. The list of successful applicants will be published in a later issue of The Journal.

Dr. Winston L. Summerlin of Gainesville has returned to his practice from a nine month teaching and postgraduate study tour at the Tulane University of Louisiana School of Medicine.

Dr. John F. Lovejoy of Jacksonville was invited to be the guest of Dr. A. R. Shands, president of the American Orthopedic Association, at the organization's annual meeting in Bretton Woods, N. H.

Dr. Ralph S. Sappenfield of Miami has been elected chairman of the section on anesthesiology of the American Medical Association.

Dr. Rodes C. Garby of St. Petersburg has been elected president of the Pinellas County Tuberculosis and Health Association.

Dr. Carl M. Pults of Lake Worth was installed as president of the Rotary Club on June 29.

Drs. Joseph B. Ganey and Richard V. Meaney of Bradenton spoke on two viewpoints on the use of the X-ray in medical pathology at a luncheon meeting of the Rotary Club of that city on June 22.

Dr. William C. Hutchison of Hialeah spoke at a meeting of the Upper Keys Kiwanis Club on July 2. His subject was lung cancer.

Dr. Floyd K. Hurt of Jacksonville took a two week postgraduate course in pediatric roentgenology in Boston in May.

Dr. Morton M. Halpern of Miami was installed as president of the Heart Association of Greater Miami on June 17. Dr. Robert V. Edwards of South Miami was installed as vice president, and Dr. Jim S. Jewett of Coral Gables, secretary. Dr. Paul N. Unger of Miami Beach was chosen president-elect.

Dr. J. K. David Jr. of Jacksonville spoke on "Blood Values of the Newborn Including Discussion of Rh Factor," at the regular monthly meeting of the Duval County Academy of General Practice on July 27.

Dr. Charles A. Schwarz of Miami Shores entered medical service with the U. S. Army on July 1, 1954, with the rank of captain.

Dr. Joshua C. Dickinson of Tampa, president-elect of the American Roentgen Ray Society, will be installed as president and will deliver his Inaugural Address on September 21 at the opening session of the Fifty-Fifth Annual Meeting of the Society. The meeting, which will be held at the Shoreham Hotel, Washington, D. C., will continue through September 24.

Dr. Raney A. Oven of Tallahassee took a course on polio care in Houston, Tex., in July.

Dr. Leo M. Levin of Miami Beach was installed as president of the Miami Phi Delta Epsilon chapter at the medical fraternity's annual installation dinner-dance on July 17. Other officers installed were: Drs. William Wickman, Miami, vice president; Jesse O. Halpern, secretary; Richard D. Shapiro, treasurer; Stanley E. Schwartz, sergeant-at-arms; Maurice J. Rose, senator; Victor Kugel, alternate senator, and Maurice Zimmerman, historian, all of Miami Beach.

Keys denoting a quarter century of service to the medical profession were presented to Drs. Max Pepper, Miami, and Maurice I. Edelman and Julius R. Pearson, Miami Beach.

Dr. Wade S. Rizk of Jacksonvile attended the Silver Jubilee commemorating the twenty-fifth anniversary of his graduation class at Georgetown University, Washington, D. C., on June 5 and 6.

Dr. Rizk gave a talk on "The Contribution of X-Rays to Medicine" at a meeting of the Southside Kiwanis Club on June 24.

Dr. Paul J. McCloskey of Tampa was awarded a prize for his "outstanding contribution" to the Greater Tampa Chamber of Commerce on July 14.

Drs. Paul N. Unger of Miami Beach and Scheffel H. Wright of Miami are co-chairmen of a committee of the Heart Association of Greater Miami on community service. The committee will give special attention this year to a program of job placement for persons handicapped by cardiovascular ailments.

Dr. Joseph H. Lucinian of Miami announces the association of Dr. Carlos G. Llanes for the practice of general radiology.

The American College of Chest Physicians held its Twentieth Annual Meeting in San Francisco, June 17-20. Dr. M. Jay Flipse of Miami is Regent for this District, and Dr. Arnold S. Anderson of St. Petersburg serves as Governor of the College for Florida.

Dr. Ralph J. Greene of Perry recently celebrated the fortieth anniversary of the establishment of his practice in Taylor County. It is estimated that Dr. Greene has attended at the birth of over 1,000 babies during his years of service.

Dr. L. H. Paul of Bonifay was honored on August 1 for 46 years of medical service to the community. Several hundred residents of Holmes County gathered at Memorial Field to pay homage to Dr. Paul. The day was proclaimed "Dr. Paul Day," and many of the "babies" which he delivered were present for the celebration.

Dr. Sidney Halpern of Jacksonville is a vice president of the newly-formed civic club, The Sertoma Club, and Dr. Aaron Z. Oberdorfer is a committee chairman.

Dr. George L. Emmel of Gainesville addressed the health education section of the State Home Demonstration Short Course at the University of Florida on July 14. Members of home demonstration clubs from throughout Florida were on the campus for the course which was scheduled for the entire week. The activities were part of the Rural Health Program of the Florida Medical Association, Florida Agricultural Extension Service, Florida State Board of Health and the Florida Farm Bureau.

Dr. Joseph Canipelli of Jacksonville gave a talk on "Cancer of the Body" at a meeting of the Christian Women's Fellowship, Riverside Avenue Christian Church, in May.

Dr. Hugh A. Carithers of Jacksonville attended a meeting of the Committee on Foetus and Newborn of The American Academy of Pediatrics in Washington in June.

Dr. James F. Speers of Titusville has returned to his position as head of the Brevard and Osceola County Health Departments after a year's leave of absence. Dr. Speers has been taking graduate work at the University of North Carolina.

Dr. Oscar L. Kelley of Palm Beach is chairman of a committee to study and design the program to be followed by the Heart Clinic of Palm Beach County. Members of the committee include Drs. Clarence L. Brumback, Saul D. Rotter and Ralph M. Overstreet Jr., of West Palm Beach; Drs. Wm. E. Van Landingham and Alvin E. Murphy, of Palm Beach; and Dr. Sidney Davidson of Lake Worth.

Dr. Turner Z. Cason of Jacksonville is a director of the Council of Social Agencies for the next three years.

Dr. Gary E. Turner of Jacksonville took part in a television panel in May on "The Importance of Early Recognition of Mental Illness."

Dr. Lorenzo L. Parks of Jacksonville spoke at a meeting of the Confederate Flag Chapter, United Daughters of the Confederacy, in May. His subject was a "Review of Medical Service During the War Between the States."

Dr. Dorothy D. Brame of Orlando attended the International Congress of Obstetrics and Gynecology in Geneva, Switzerland.

Drs. Whitman C. McConnell of St. Petersburg and Russell B. Carson of Fort Lauderdale were recent visitors at the Association's office in Jacksonville.

Dr. Ray O. Edwards Jr. of Jacksonville talked on "Preparing Your Child for School" at the Hyde Park School summer round-up.

Dr. A. Judson Graves of Jacksonville gave the opening address at the annual meeting of the Florida Society of X-Ray Technicians held in Miami in May.

Dr. Meredith F. Campbell of Miami spoke before the Cuban National Pediatric Society on July 17 in Havana, Cuba. His subject was the indications for urologic examination in infants and children.

Dr. Andrew G. Brown of Miami has been appointed a member of the Florida State Board of Medical Examiners, according to announcement by the Governor's office.

Dr. Gunnard J. Antell of Coral Gables presented a paper on "Pediatric Tools in the Evaluation of Growth and Development" before the Aereal Meeting of the Finnish Pediatric Society in Helsinki and the Danish Pediatric Association in Copenhagen in July.

Dr. William Wickman of Miami spoke on "Certain Aspects of Gall Bladder Disease," at the June 16 staff meeting of the Edgewater Hospital.

Dr. Ira K. Brandt of Coral Gables spoke on nephrosis at an open meeting of Coral Gables Lodge No. 173, Knights of Pythias on July 22.

Dr. N. Worth Gable of St. Petersburg has returned to his practice after Reserve duty tour at Fort McClellan, Ala.

Dr. Irby H. Black of Live Oak attended the Southeastern Medical Seminar in Saluda, N. C., July 25-31.

COMPONENT SOCIETY NOTES

Bay

The Bay County Medical Society has paid 100 per cent of its state dues for 1954.

Dade

At the regular monthly meeting of the Dade County Medical Association on August 3, Drs. Martin G. Gould and Donald W. Smith spoke on "Blood Transfusions with Special Reference to Use of Plasma and Plasma Expanders."

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Appleby, Leonard W., Lake Worth
Baker, Roy M., Jacksonville
Colbert, Walter T., Pensacola
Davis, Robert J., Tampa
Emlet, John R., Pensacola
Gillespie, Samuel D. Jr., Pensacola
McPherson, A. Ziegler, Tampa
Park, Charles L. Jr., Sanford

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Dramamine has become accepted in the control of a variety of clinical conditions characterized by vertigo and is recognized as a standard for the management of motion sickness.

Vertigo, according to Swartout, is primarily due* to a disturbance of those organs of the body that are responsible for body balance. When the posture of the head is changed, the gelatinous substance in the semi-circular canals begins to flow. This flow initiates neural impulses which are transmitted to the vestibular nuclei. From this point impulses are sent to different parts of the body to cause the symptom complex of vertigo.

Some impulses reach the eye muscles and cause nystagmus; some reach the cerebellum and skeletal muscles and righting of the head results; others activate the emetic center to result in nausea, while still others reach the cerebrum making the person aware of his disturbed equilibrium. *Vertigo may be caused by a disease or abnormal stimuli of any of these tissues involved in the transmission of the vertigo impulse, including the cerebellum and the end organs.*

A possible explanation of Dramamine's action is that it depresses the overstimulated labyrinthine structure of the inner ear. Depression, therefore, takes place at the point at which these impulses, causing vertigo, nausea and similar disturbances, originate. Some investigators have suggested that Dramamine may have an additional sedative effect on the central nervous system.

Repeated clinical studies have established Dramamine as valuable in the control of the symptoms of Ménière's syndrome, the nausea and vomiting of pregnancy, radiation sickness, hypertension vertigo, the vertigo of fenestration procedures, labyrinthitis and vestibular dysfunction associated with antibiotic therapy, as well as in motion sickness.

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The site of Dramamine's action is probably in the labyrinthine structure.

*Swartout, R., III, and Gunther, K.: "Dizziness:" Vertigo and Syncope, GP *8*:35 (Nov.) 1953.

WOMAN'S AUXILIARY

TO THE

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MRS. DAVID R. MURPHEY JR. Research and Romance of Medicine .....*Tampa*
MRS. A. FRED TURNER JR., Nominating.....*Orlanda*

Fall Begins Busy Season for Florida Auxiliary

At the time of this writing, plans for the fall and winter season activities of the Woman's Auxiliary to the Florida Medical Association are becoming advanced, and we are looking forward not only to a busy but to a profitable eight months until the time of our next meeting in St. Petersburg, April 3-6, 1955.

The midyear Board Meeting and Conference of County Presidents and Presidents-elect will be held in St. Petersburg at the Tides Hotel on Sept. 21-22, 1954. This meeting is being looked forward to by the officers, chairmen and the county presidents, presidents-elect and/or vice presidents. The meeting will open with a conference for chairmen and county personnel at 2:30 p.m. on Tuesday, September 21. Mrs. Samuel S. Lombardo, President-elect of the Florida Auxiliary, is in charge of this conference and will be the presiding officer. Mrs. Lombardo is planning an excellent program and it is hoped that we shall have 100 per cent attendance from the county auxiliaries.

The Executive Board Meeting will be held the following morning at 9:30 a.m., and the business of the Auxiliary will be attended to at this meeting.

Not forgetting the social side and fellowship of such meetings, a dinner will be held on the evening of September 21. Entertainment is to be announced. At the noon hour on September 22, a luncheon will be held. The fun and social hours of the Auxiliary mean much in our contacts with each other.

During this meeting, county presidents will present plans for their auxiliaries and we shall attempt to learn from each other.

The District Workshops to be held at the District Meetings of the Florida Medical Association are being planned by our vice presidents, who are in charge of the programs and will preside at these meetings. Mrs. William D. Rogers will be in charge of the meeting in District A on October 11; Mrs. Albert G. Love IV, District B, October 13; Mrs. John P. Ferrell, District C., October 15; and Mrs. Charles McD. Harris Jr., District D, October 14. We are looking for a big turnout for these meetings from the auxiliaries and counties in each district.

In November, representation from Florida will be present in St. Louis for the Southern Medical Association and Auxiliary meetings. Mrs. Lee Rogers Jr., Cocoa, is the councilor for the auxiliary from Florida; Mrs. Perry D. Melvin, Miami, is the chairman of the Jane Todd Crawford Memorial Loan Fund, and Mrs. Richard F. Stover, Miami, is chairman of revisions for this organization. Meetings of the Southern Auxiliary will be held in the Statler Hotel, St. Louis, November 8-11. Many other women from Florida are planning to attend.



Also, from November 16 through 18, Mrs. Samuel S. Lombardo, President-elect, and Mrs. Richard F. Stover, President, of the Florida Auxiliary will attend the annual Conference of State Presidents, Presidents-elect and National Committee Chairmen at the Drake Hotel in Chicago. This conference takes the place of a mid-interim meeting for the national auxiliary.

The Clinical Session of the A.M.A. is to be held in Miami this year November 28-December 2, and many of the auxiliary members from Florida will be present with their husbands, though no official auxiliary meetings take place at this time.

All these meetings, though important, do not take the place of the importance of the work of the local auxiliary, for it is through them that our projects are advanced. In between meetings, the members of the Florida Auxiliary will have started their work on our projects and we will see them advancing all through this year. The wives of Florida doctors are busy at their tasks of advancing health education, aiding the medical associations and societies, learning more how to do the job and serving the health needs in their communities. The Woman's Auxiliary to the Florida Medical Association takes off its hat to its members who do such an excellent work throughout the year.

Mrs. Richard F. Stover, President



Florida Takes Sunshine of Her Smiles to San Francisco Convention

Standing left to right: Mrs. Edward F. Fox, Mrs. Donald F. Marion, Dade County; Mrs. Francis D. Pierce, Mrs. George T. F. Rahilly, Broward County; Mrs. John M. Butcher, Sarasota County; Mrs. V. Marklin Johnson, Palm Beach County; Mrs. Randolph Shevach, Mrs. Milton M. Coplan, Dade County.

Seated left to right: Mrs. Frederick P. Poppe, Dade County; Mrs. Burns A. Dobbins Jr., Broward County; Mrs. Richard F. Stover, Dade County; Mrs. James N. Patterson, Hillsborough County; Mrs. John R. Ramey, Dade County.

Present and smiling but not in picture: Mrs. Sullivan G. Bedell, Mrs. John H. Mitchell, Duval County; Mrs. Jack Q. Cleveland, Mrs. R. Spencer Howell, Mrs. Paul S. Jarrett and Mrs. William C. Phillips, Dade County.

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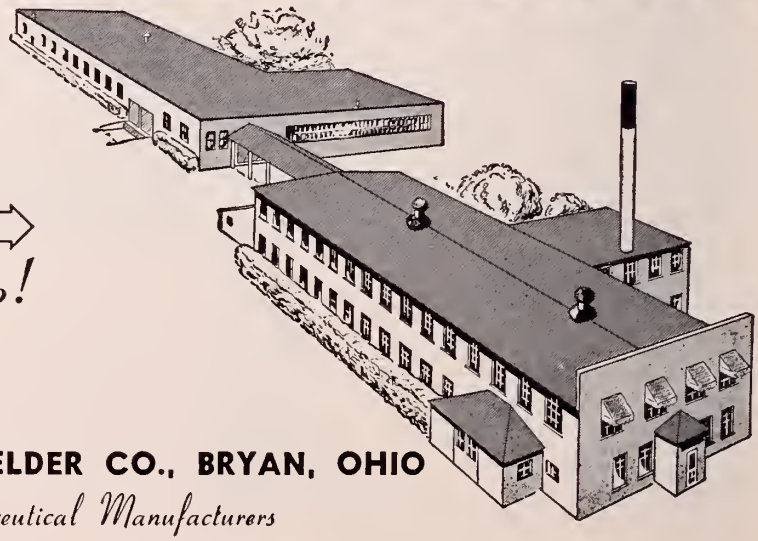
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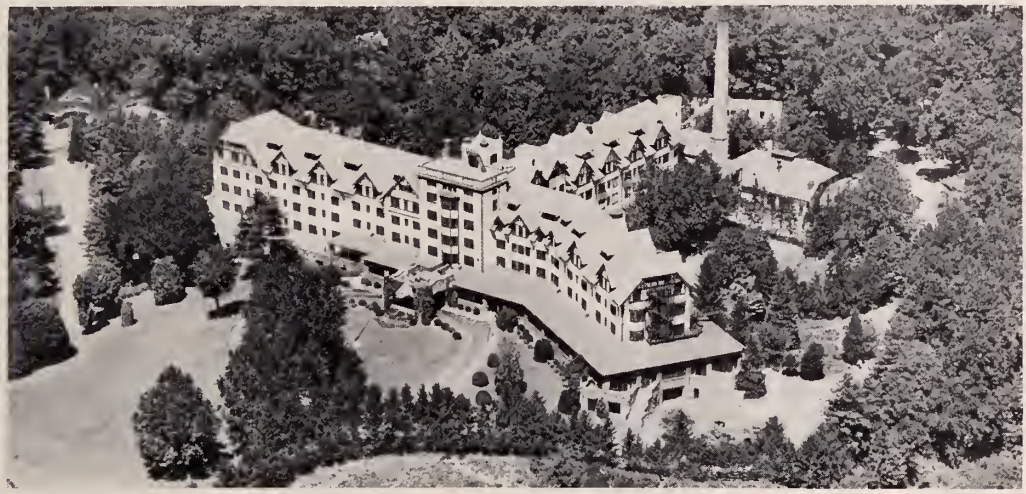
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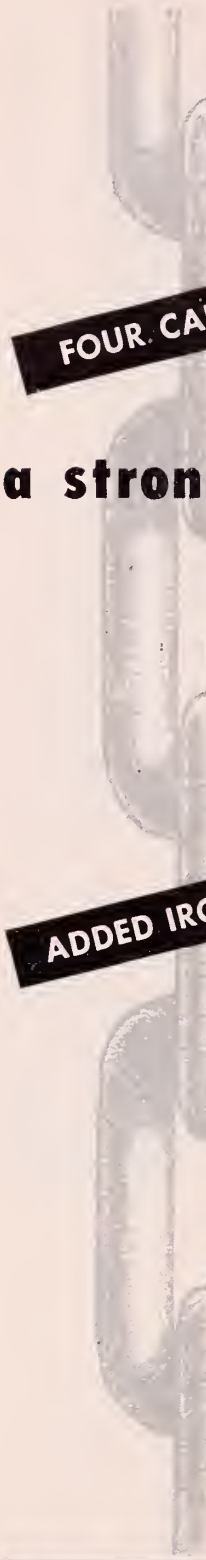
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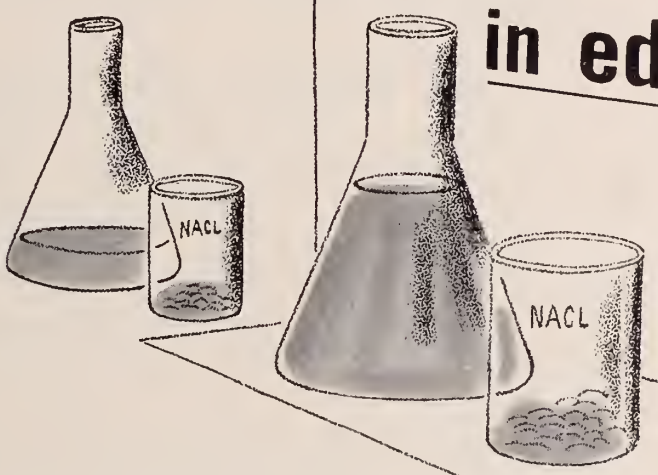
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1. Nielsen, A. L., Bechgaard, P., and Bang, H. O.: Low-Salt Diet in Treotment of Congestive Heart Foilure. *Brit. Med. Jour.*, 1:1349, June 16, 1951.

2. Brown, W. E., and Sutherland, C. G.: Control of Edemo in Pregnancy. *GP*, 8:65, Nov., 1953.

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Basic foods requiring primary consideration for providing adequate daily nutrition in such patients are:

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>
> "In order to restore depleted protein levels, it is necessary to increase the protein component by adding meat servings . . . "[1]

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1. Shuman, C. R., and Wohl, M. G.: Nutritional Aspects of Heart Failure, J. Clin. Nutrition 2:5 (Jan.-Feb.) 1954.

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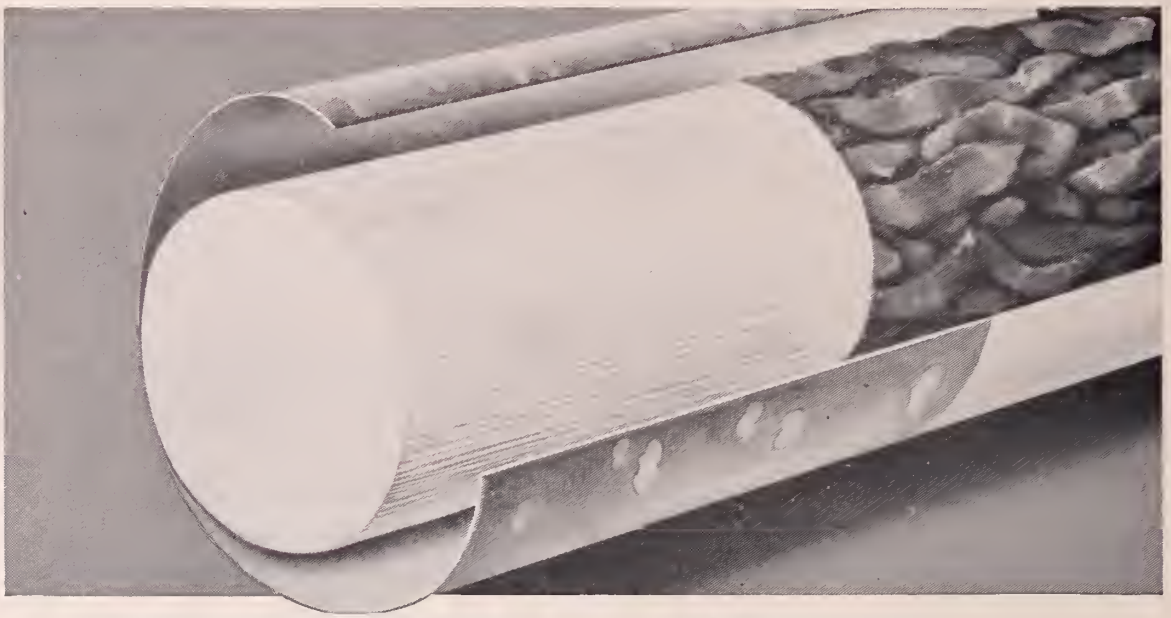
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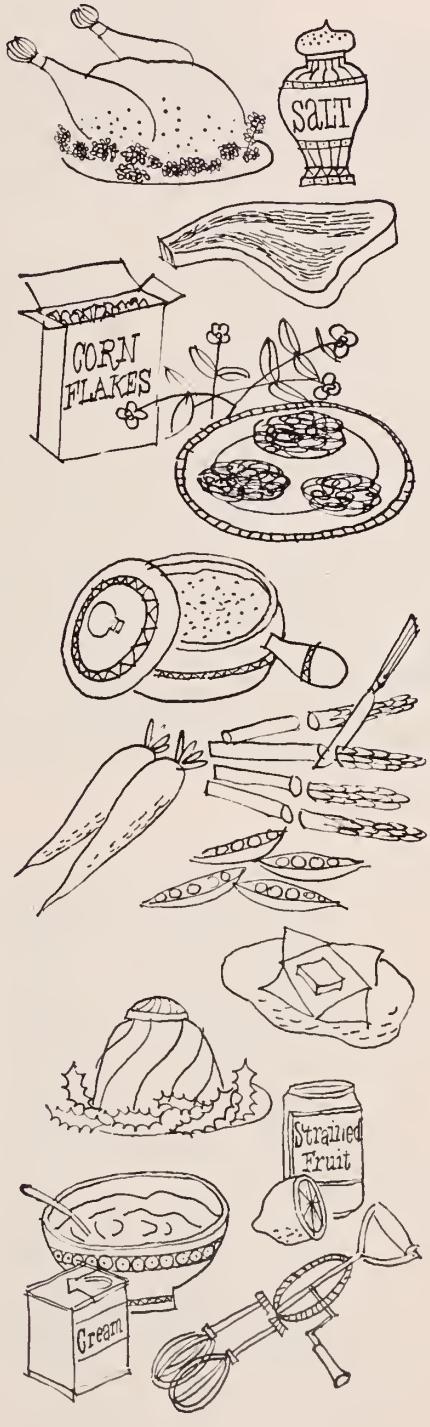
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Variety in taste and texture of foods must become the "spice" of a bland diet now that your patient can't have sharp seasonings and strongly flavored vegetables. These "do's" will help keep his diet tempting to both eye and palate.



For the "meat" of the meal—

Suggest that beef, lamb, and poultry be roasted or broiled and seasoned with salt and mild herbs.

Meat patties stay tender when crushed corn flakes and a little water are added to the finely ground beef. Salt and a hint of thyme or marjoram give savor.

Fish soufflé—flaked fish in any soufflé recipe—is a delicate delight when the top is crisped with cracker meal and butter.

Add the "trimmings" with imagination—

Vegetables such as string beans, peas, asparagus tips, spinach and carrots may be cooked and served whole if young and tender. Otherwise they must be puréed. Potatoes may be boiled, baked, or mashed.

Salads of molded gelatin are pretty to look at—better to eat. Your patient may like one made of strained beets livened with lemon juice, chilled and turned out of the mold on shredded tender lettuce.

Desserts add the final fillip. He can try applesauce added to whipped lime gelatin, chilled and topped with custard sauce. Or for a party touch, he can sweeten chilled strained fruit, add a squeeze of lemon, and fold into whipped cream or whipped evaporated milk.

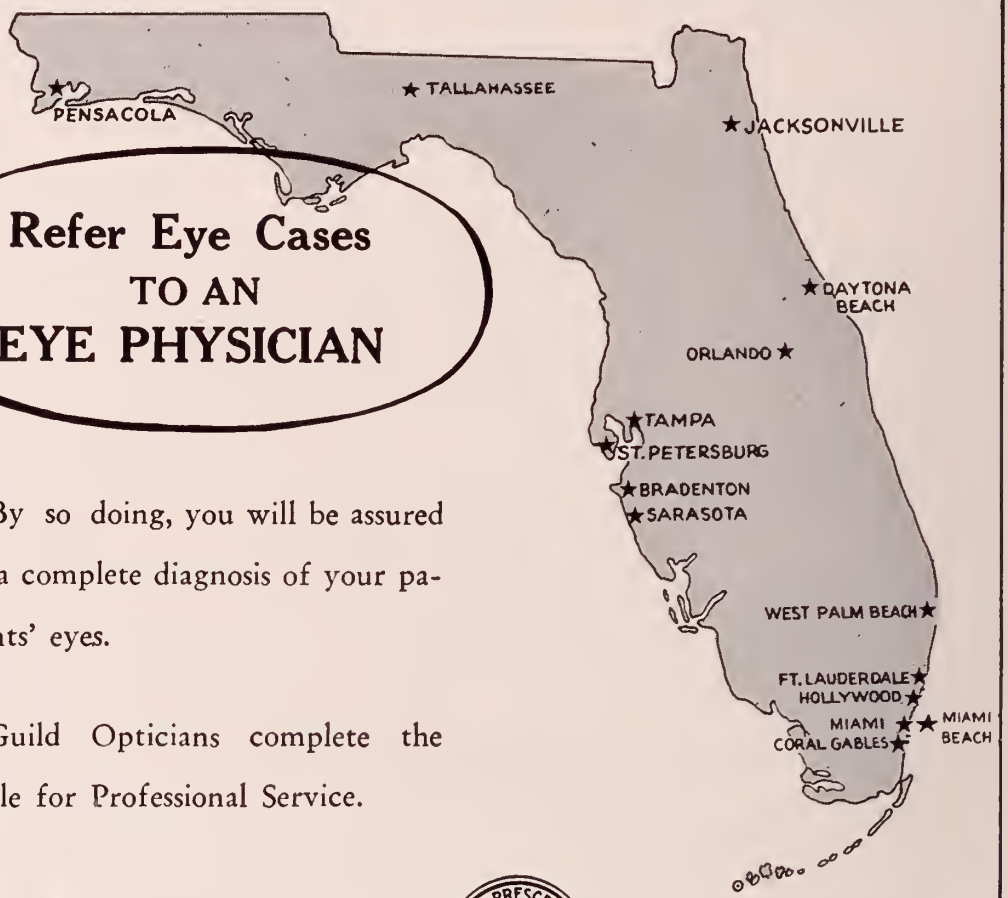
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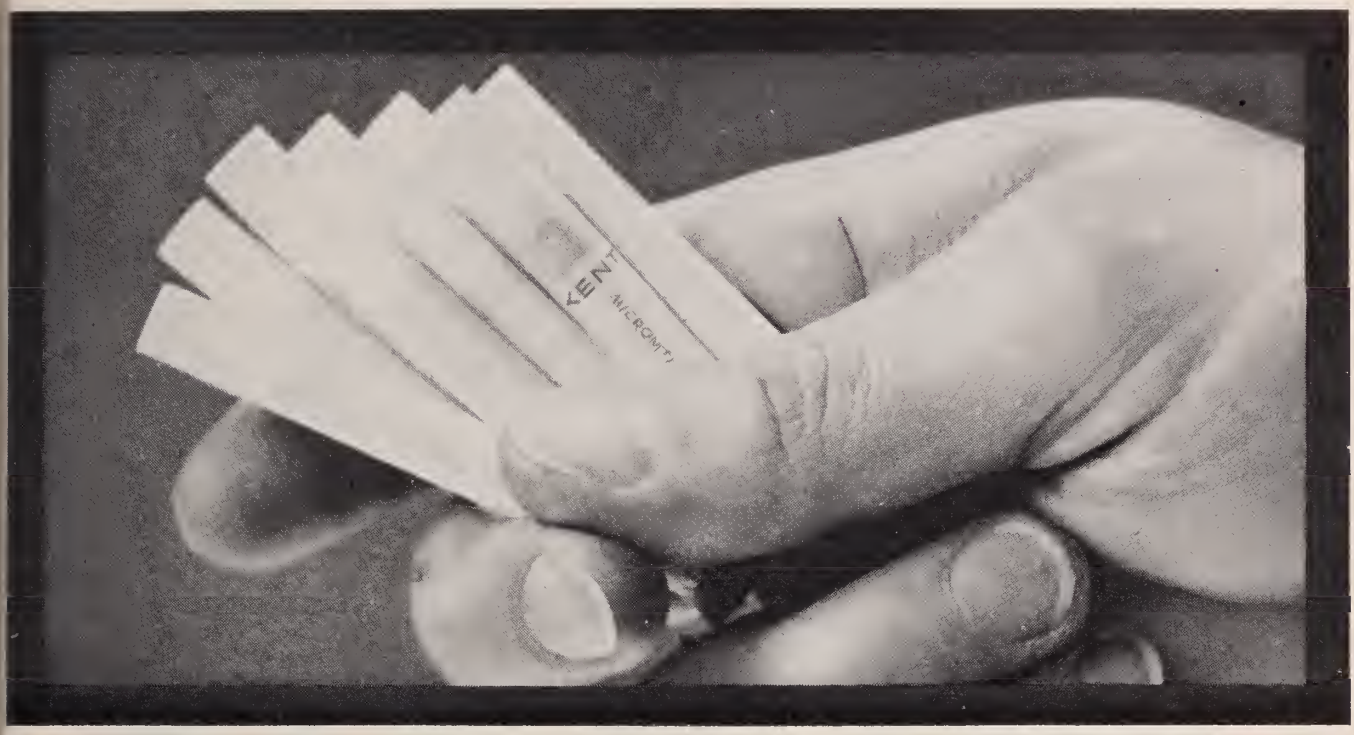
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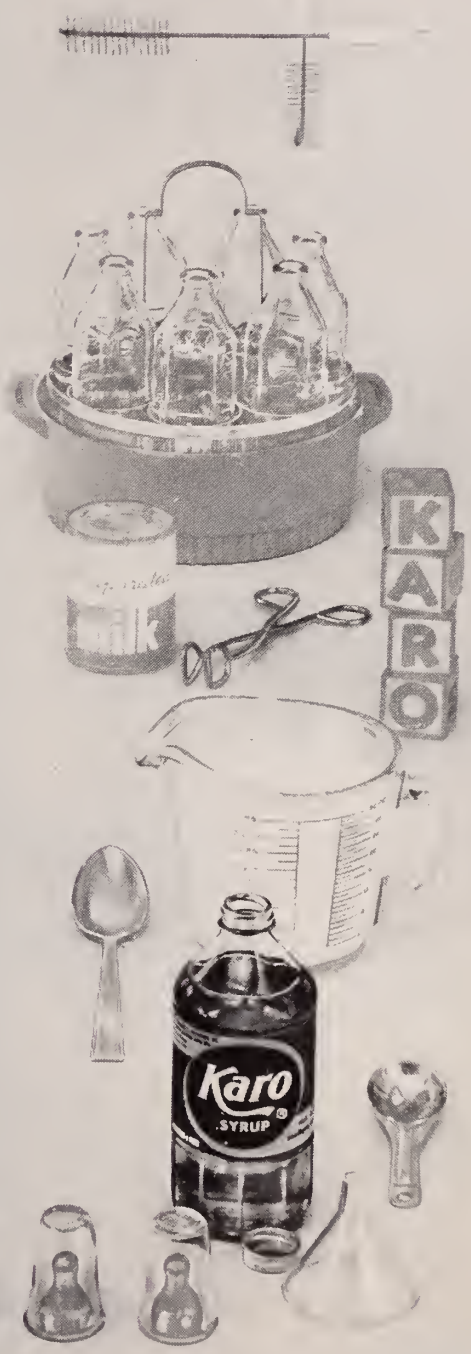
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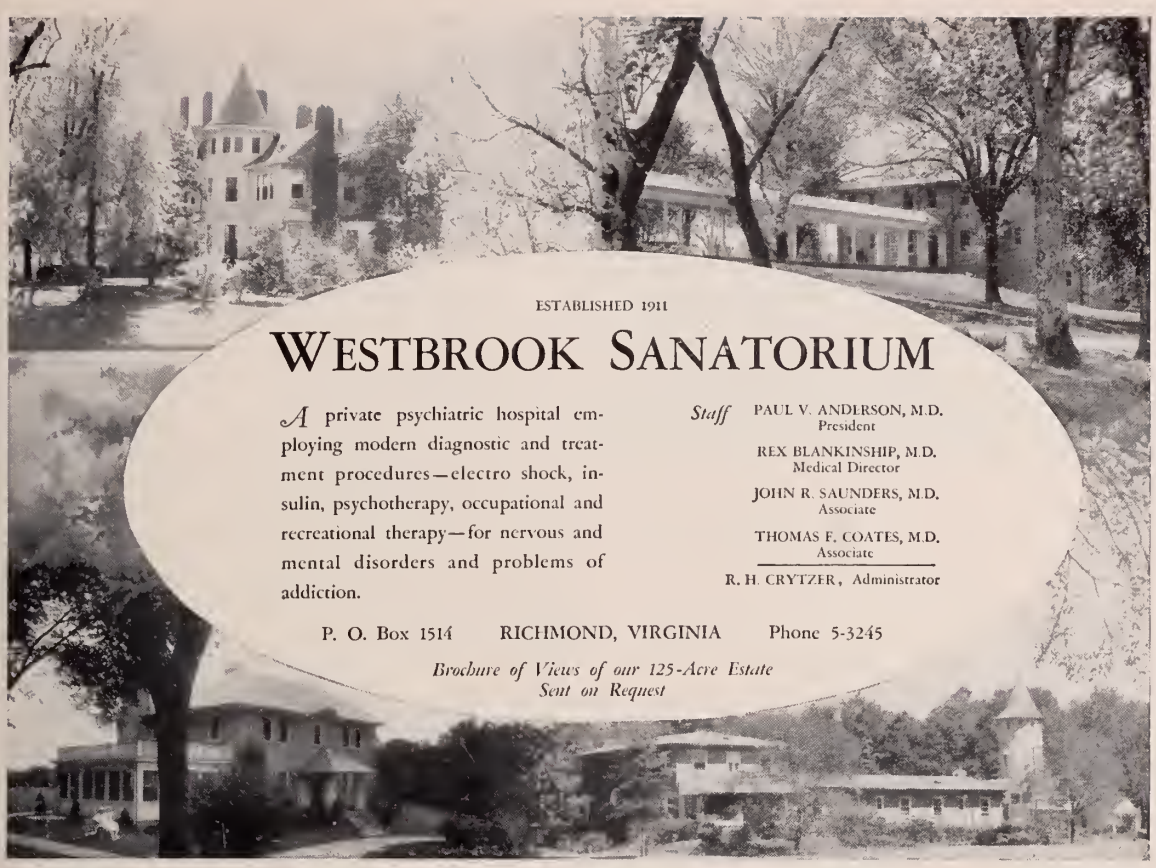
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	Duncan T. McEwan, Orlando	Samuel M. Day, Jacksonville	St. Petersburg, Apr. 3-6, '55
Florida Medical Districts	Francis H. Langley, St. Petersburg	Council Chairman	
A-Northwest	William H. Hixon, Pensacola	George S. Palmer, Tallahassee	Marianna, Oct. 11, '54
B-Northeast	Henry J. Babers Jr., Gainesville	Thomas C. Kenaston, Cocoa	Sanford, Oct. 13, '54
C-Southwest	Clyde O. Anderson, St. Petersburg	James R. Boulware Jr., Lakeland	Sarasota, Oct. 15, '54
D-Southeast	James R. Sory, West Palm Beach	Russell B. Carson, Ft. Lauderdale	Vero Beach, Oct. 14, '54
Florida Specialty Societies			
Academy of General Practice	Leonard L. Weil, Miami Beach	Leon S. Eisenman, Hialeah	St. Petersburg, Apr. 3, '55
Allergy Society	Solomon D. Klotz, Orlando	Edwin P. Preston, Miami	" "
Anesthesiologists, Soc. of	R. Gaylord Lewis, West Palm Beach	Harry E. Bierley, West Palm Beach	" "
Chest Phys., Am. Coll., Fla. Chap.	DeWitt C. Daughtry, Miami	Jack Reiss, Coral Gables	" "
Derm. and Syph., Soc. of	Hollis F. Garrard, Miami	Joseph A. J. Farrington, Jacksonville	" "
Health Officers' Society	Thomas E. Morgan, Jacksonville	Lorenzo L. Parks, Jacksonville	" "
Industrial and Railway Surgeons	Plumer J. Manson, Miami	John H. Mitchell, Jacksonville	" "
Neurology & Psychiatry	Sullivan G. Bedell, Jacksonville	Roger E. Phillips, Orlando	" "
Ob. and Gynec. Society	Harold G. Nix,Tampa	Reuben B. Chrisman Jr., Miami	" "
Ophthal. & Otol., Soc. of	G. Tayloe Gwathmey, Orlando	Carl S. McLemore, Orlando	" "
Orthopedic Society	John F. Lovejoy, Jacksonville	Newton C. McCollough, Orlando	" "
Pathologists, Society of	Millard B. White, Sarasota	James B. Leonard, Tampa	" "
Pediatric Society	C. Jennings Derrick, W. Palm Bch.	Wesley S. Nock, Coral Gables	St. Petersburg Bch., Oct. 22-24, '54
Proctologic Society	Claude G. Mentzer, Miami	George Williams Jr., Miami	St. Petersburg, Apr. 3, '55
Radiological Society	A. Judson Graves, Jacksonville	James T. Shelden, Lakeland	" "
Surgeons, Am. Coll., Fla. Chapter	Frederick J. Waas, Jacksonville	C. Frank Chunn, Tampa	" "
Urological Society	Linus W. Hewit, Tampa	Frank J. Pyle, Orlando	" "
Florida—			
Basic Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, Nov. 6, '54
Blood Banks, Association	John T. Stage, Jacksonville	John B. Ross, Jacksonville	St. Petersburg, 1955
Blue Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	Palm Beach Shores, Nov. 17, '54
Blue Shield of Florida, Inc.	David R. Murphey Jr., Tampa	Jack O. W. Rash, Miami	
Cancer Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	St. Petersburg, Apr. 3, '55
Clinical Diabetes Assn.	Fred Mathers, Orlando	Edward R. Smith, Jacksonville	Orlando, Oct. 21-22, '54
Dental Society, State	Robt. Thoburn, D.D.S., Daytona Bch	J. E. Edwards, D.D.S., Coral Gables	Jacksonville, Apr. 23-25, '55
Heart Association	Alvin E. Murphy, Palm Beach	Daniel R. Usdin, Jacksonville	April 1955
Hospital Association	Mr. J. F. Wymer Jr., W. Palm B.	Mrs. Mary Reeder, Miami	
Medical Examining Board	Frank D. Gray, Orlando	Homer L. Pearson Jr., Miami	Jacksonville, Nov. 21-23, '54
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
Nurse Anesthetists, Fla. Assn.	Miss Dorothy Jackson, C. Gables	Mrs. Lulla F. Bryan, Miami	Palm Bch. Shores, Nov. 17-19, '54
Nurses Association, State	Mrs. Bertha King, Tampa	Mrs. Idalyn Lawthon, Tampa	Jacksonville, Oct. 30-Nov. 3, '54
Pharmaceutical Association, State	Mr. J. L. McDonald, St. Augustine	Mr. R. Q. Richards, Ft. Myers	Clearwater, May '55
Public Health Association	Frank M. Hall, Gainesville	Mr. Fred B. Ragland, Jacksonville	Miami Beach, Oct. 21-23, '54
Trudeau Society	Lawrence C. Manni, Tallahassee	Simon D. Doff, Jacksonville	May, 1955
Tuberculosis & Health Assn.	Judge Ernest E. Mason, Pensacola	Mrs. L. C. Conant, Fort Myers	
Woman's Auxiliary	Mrs. Richard F. Stover, Miami	Mrs. S. J. Wilson, Ft. Lauderdale	St. Petersburg, Apr. 3, '55
American Medical Association	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	Atlantic City, June 6-10, '55
A.M.A. Clinical Session	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	Miami, Nov. 29-Dec. 2, '54
Southern Medical Association	Alphonse McMahon, St. Louis	Mr. C. P. Loranz, Birmingham	St. Louis, Nov. 8-11, '54
Alabama Medical Association	J. M. Donald, Birmingham	Douglas L. Cannon, Montgomery	Montgomery, Apr. 21-23, '55
Georgia, Medical Assn. of	Peter B. Wright, Augusta	David Henry Poer, Atlanta	Augusta, May 1-4, '55
S. E. Hospital Conference	Mr. John W. Gill, Vicksburg, Miss.	Mr. Pat Groner, Pensacola	Atlanta, Apr. 20-22, '55
Southeastern Allergy Assn.	W. L. Rucks, Memphis, Tenn.	Kath. B. MacInnis, Columbia, S. C.	Orlando, 1955
Southeastern, Am. Urological Assn.	Sam L. Raines, Memphis, Tenn.	Robert F. Sharp, New Orleans	New Orleans Mar. 20-23, '55
Southeastern Surgical Congress	J. Duffy Hancock, Louisville, Ky.	B. T. Beasley, Atlanta	Atlanta, Mar. 7-10, '55
Gulf Coast Clinical Society	Jas. N. Lockard, Pascagoula, Miss.	F. C. Minkler, Pascagoula, Miss.	Edgewater Park, Miss., Oct. 21-22,

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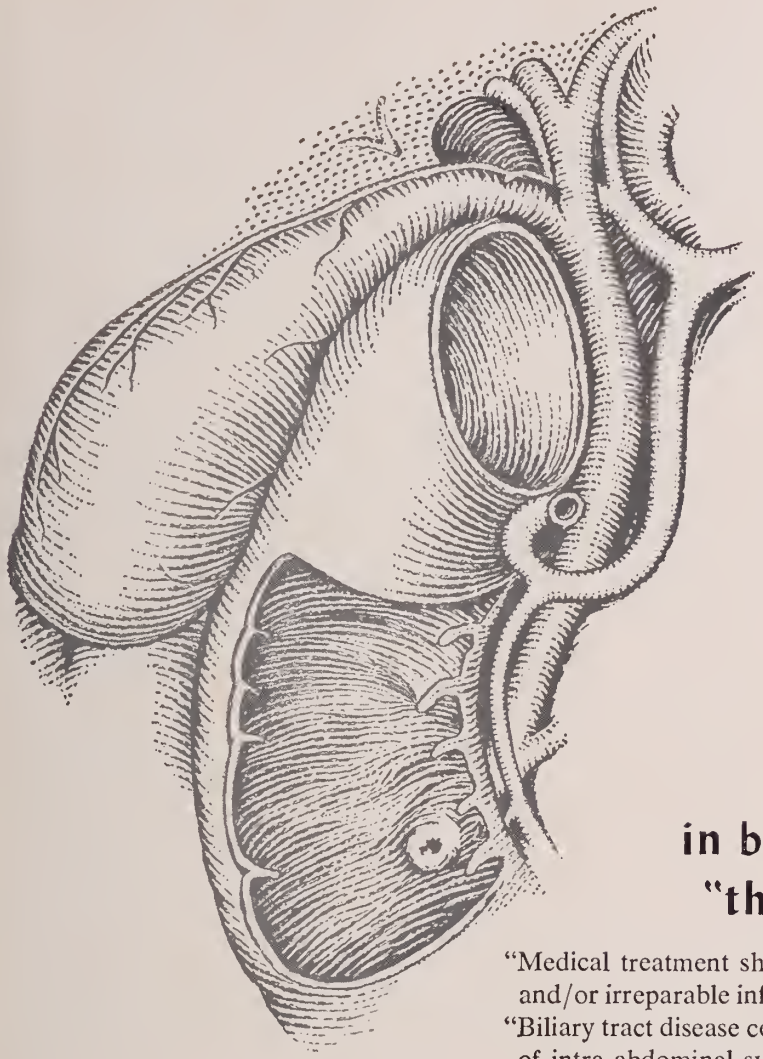
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County Medical Societies of Florida

SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Total Members
Alachua	Henry H. Graham, Gainesville	Glenn O. Summerlin, Gainesville	2nd Tues.	51
***Bradford, Gilchrist, Union**				
Bay	Lemuel F. Coxe Jr., Panama City	James D. Nixon, Panama City	1st Tues.	26
Brevard	Theodore J. Kaminski, Melbourne	Paul L. Summers, Melbourne	2nd Tues.	28
Broward	Julius F. Boettner, Fort Lauderdale	George T. F. Rahilly, Fort Lauderdale	4th Tues.	108
Columbia	Robert B. Harkness, Lake City	Thomas H. Bates, Lake City	1st Mon.	12
***Baker, Hamilton**				
Dade	Edward W. Cullipher, Miami	Kenneth S. Whitmer, Miami	1st Tues.	668
DeSoto-Hardee-Highland-Glades	Carl J. Larsen, Avon Park	Samuel A. King, Avon Park	2nd Tues.	27
Duval	Karl B. Hanson, Jacksonville	Jackson L. Allgood Jr., Jacksonville	1st Tues.	273
***Clay**				
Escambia	Wilton E. Tugwell, Pensacola	Paul F. Baranco, Pensacola	2nd Tues.	100
***Santa Rosa**				
Franklin-Gulf	Albert L. Ward, Port St. Joe	Warren T. Weathington, Apalachicola	Last Wed.	9
Hillsborough	C. Frank Chunn, Tampa	Julien C. Pate Jr., Tampa	1st Tues.	181
Indian River	William L. Fitts 3rd, Vero Beach	Vernon L. Fromang, Vero Beach	2nd Tues.	10
Jackson-Calhoun	Jabe A. Breland, Marianna	Francis M. Watson, Marianna	Quarterly	17
Lake	J. Basil Hall, Tavares	James R. Hanson, Tavares	1st Wed.	29
***Sumter**				
Lee-Charlotte-Collier-Hendry	H. Quillian Jones, Fort Myers	James L. Bradley, Fort Myers	3rd Mon.	37
Leon-Gadsden-Liberty-Wakulla-Jefferson	George H. Massey, Quincy	Odis G. Kendrick Jr., Tallahassee	Quarterly	58
Madison	Wallace E. Winter, Madison	Julian M. DuRant, Madison		5
Manatee	Willett E. Wentzel, Bradenton	Marjorie L. Warner, Bradenton	2nd Tues.	25
Marion	William H. Anderson Jr., Ocala	Bertrand F. Drake, Dunnellon	3rd Tues.	30
***Levy**				
Monroe	Edward Gonzalez, Key West	Herman K. Moore, Key West	2nd Thurs.	12
Nassau	David G. Humphreys, Fernandina	John W. McClane, Fernandina	Last Fri.	11
Orange	Eugene L. Jewett, Orlando	Andrew W. Townes Jr., Orlando	3rd Wed.	183
***Osceola**				
Palm Beach	Thomas E. Daly, West Palm Beach	David A. Newman, Palm Beach	4th Mon.	134
Pasco-Hernando-Citrus	Frank Y. Robson, New Port Richey	W. Wardlaw Jones, Dade City	2nd Thurs.	18
Pinellas	Alvin L. Mills, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	217
Polk	Theodore C. Keramidas, Winter Haven	James T. Shelden, Lakeland	2nd Wed.	92
Putnam	Lawrence G. Hebel, Palatka	James A. Long Jr., Palatka	2nd Tues.	10
St. Johns	James J. DeVito, St. Augustine	Reuben J. Plant Jr., St. Augustine	3rd Tues.	19
St. Lucie-Okeechobee-Martin	Laurance D. Van Tilborg, Ft. Pierce	Adrian M. Sample, Fort Pierce	3rd Thurs.	21
Sarasota	Henry J. Vomacka, Sarasota	Lloyd J. Duest, Sarasota	2nd Tues.	53
Seminole	J. Clifford Boyce, Sanford	Terry Bird, Sanford	2nd Tues.	19
Suwannee	William P. Blackmon, Mayo	Hiram B. Curry, Jasper	1st Sat.	9
Taylor	George H. Warren, Perry	Walter J. Baker, Foley	Last Fri.	5
***Dixie, Lafayette**				
Volusia	Cleland D. Cochrane, Daytona Beach	Robert L. Miller, Daytona Beach	2nd Tues.	85
***Flagler**				
Walton-Okaloosa	Robert von P. Maxon, Fort Walton	Arthur G. Williams Jr., Valparaiso	3rd Thurs.	20
Washington-Holmes	Ralph H. Segrest, Bonifay	Bayllye W. Dalton, Chipley		6
				Total 2,608

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1. Segal, H.: Postgrad. Med. *13*:81, 1953. 2. O'Brien, G. F., and Schweitzer, I. L.: M. Clin. North America *37*:155, 1953. 3. Beckman, H.: Pharmacology in Clinical Practice, Philadelphia, W. B. Saunders Company, 1952, p. 361.

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Aneurysms and Artiovenous Fistulas
Mathew W. Kobak

Infectious Mononucleosis
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MIAMI, NOV. 29 - DEC. 2, 1954

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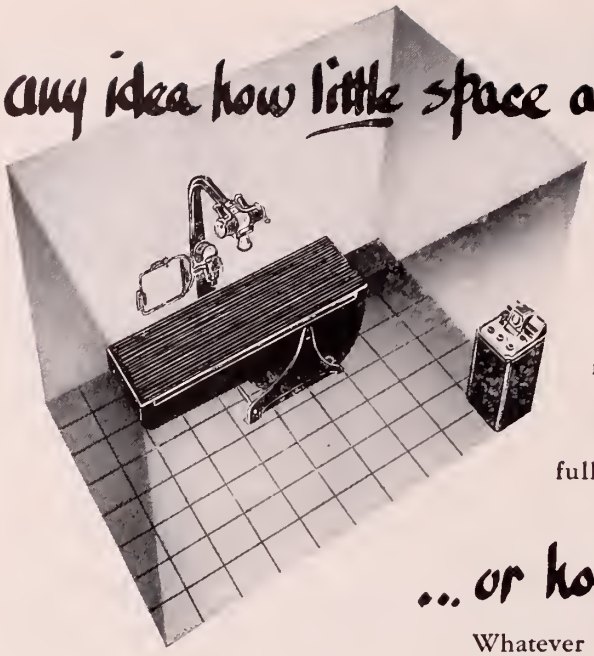
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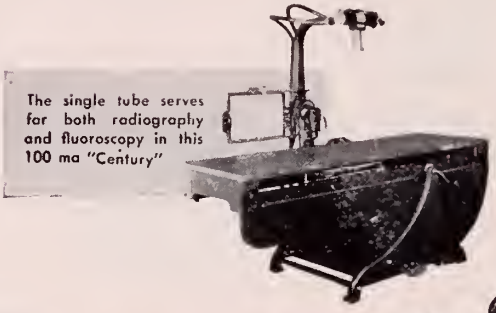
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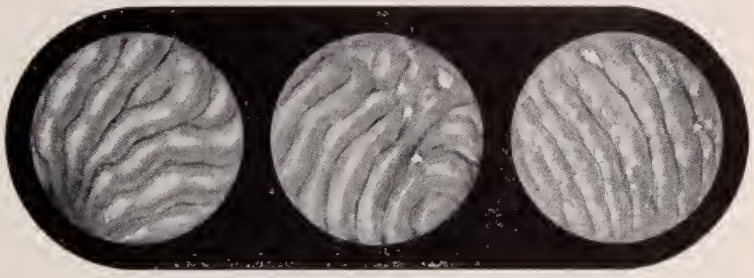
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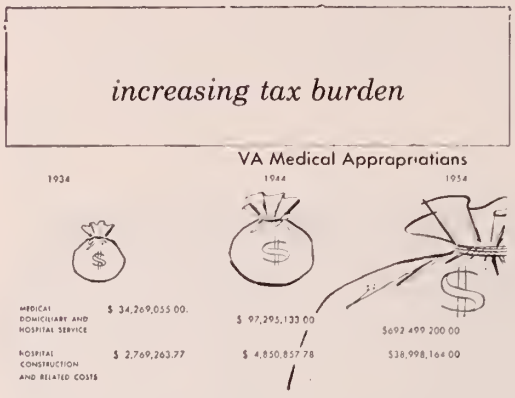
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2. Deutsch, E.: Scientific Exhibit, Gastroscopy, Interim Session A.M.A., St. Louis, December, 1953

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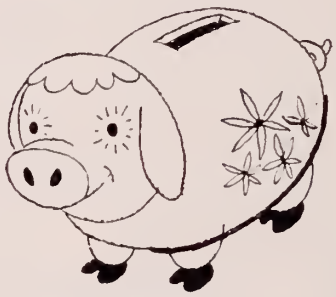
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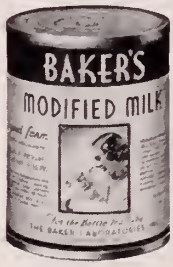
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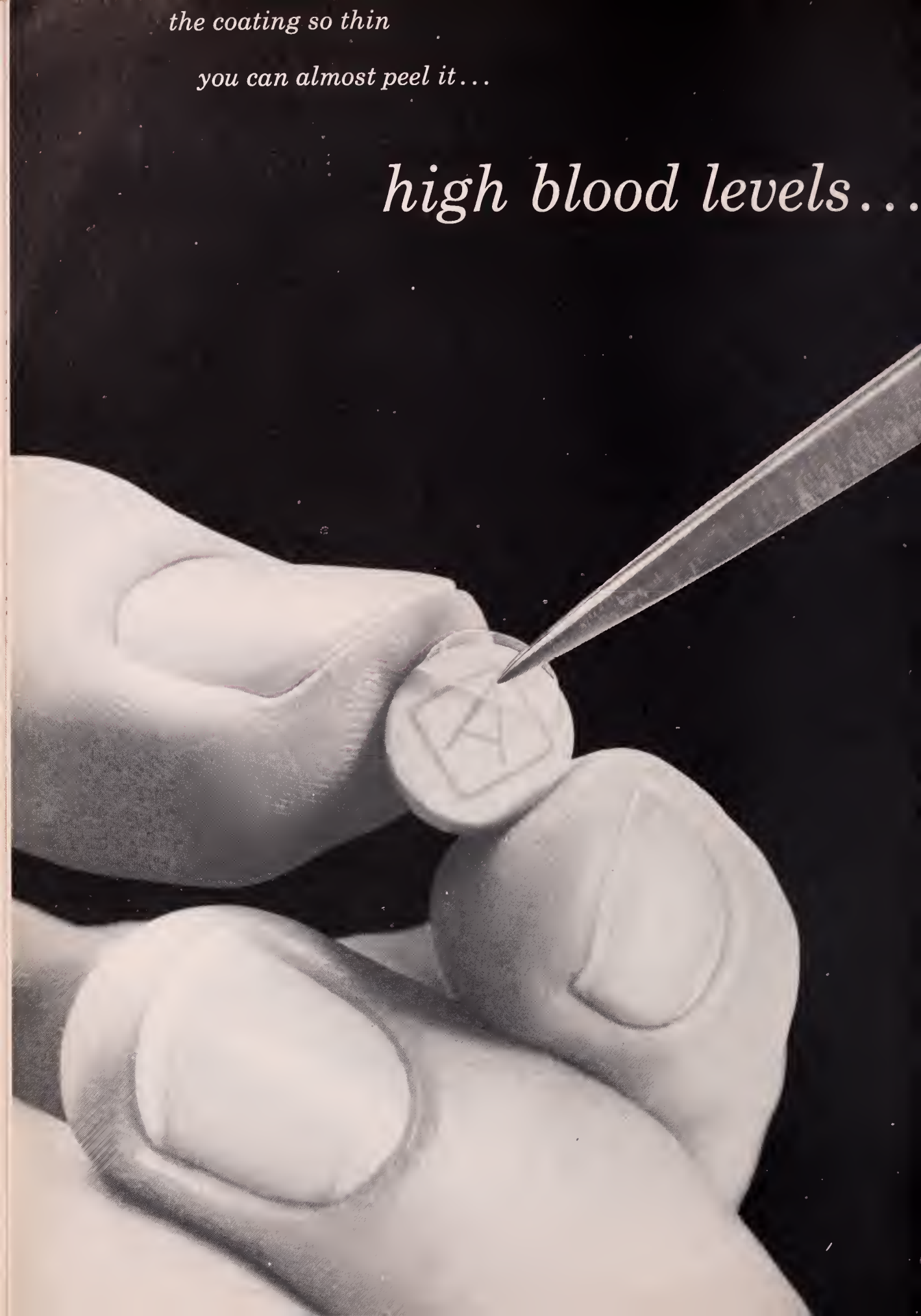
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1. Greenblatt, R. B., and Kupperman, H. S.: M. Clin. North America *30*:576 (May) 1946. 2. McGavack, T. H., in Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc., 1953, p. 225.

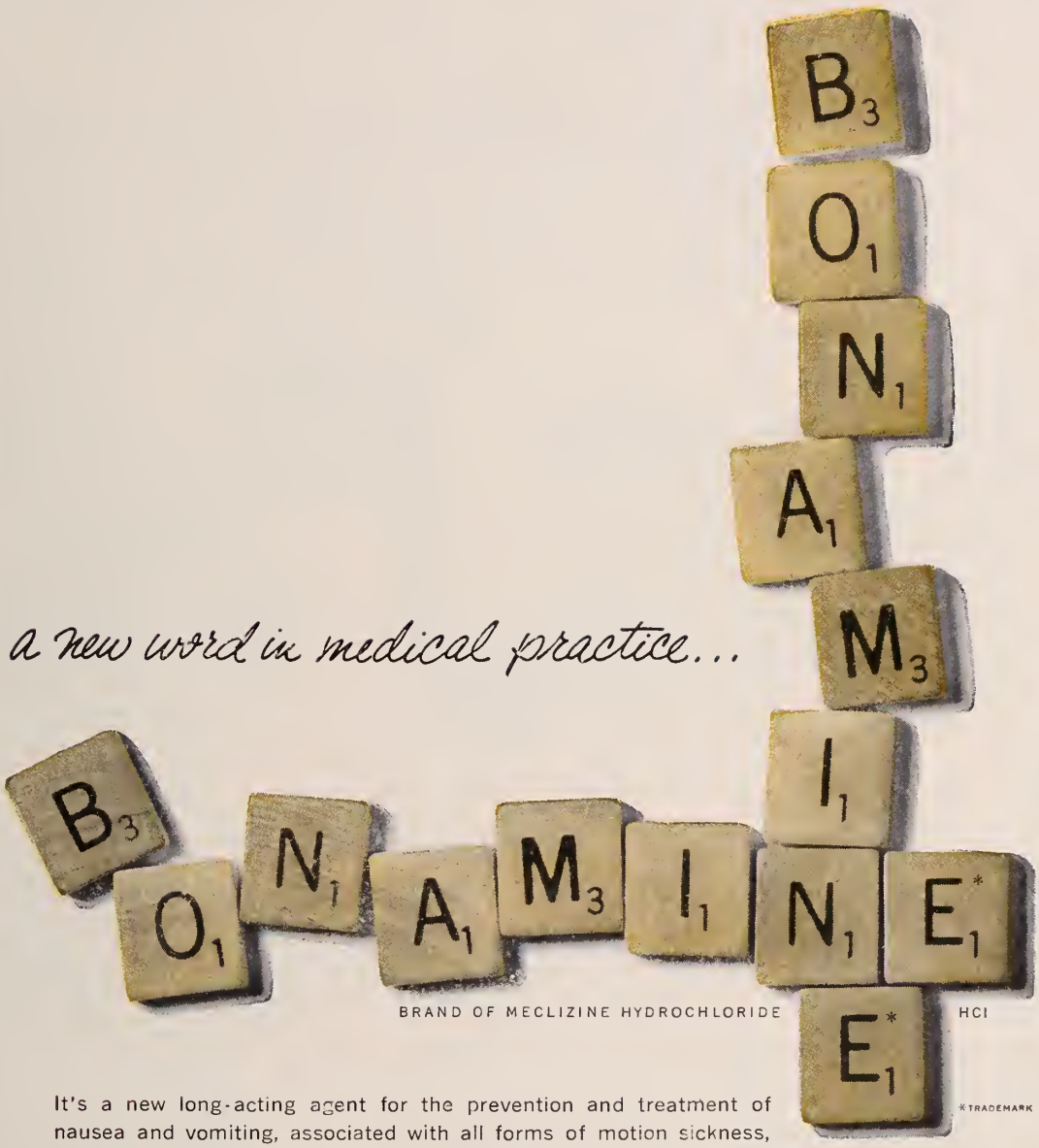
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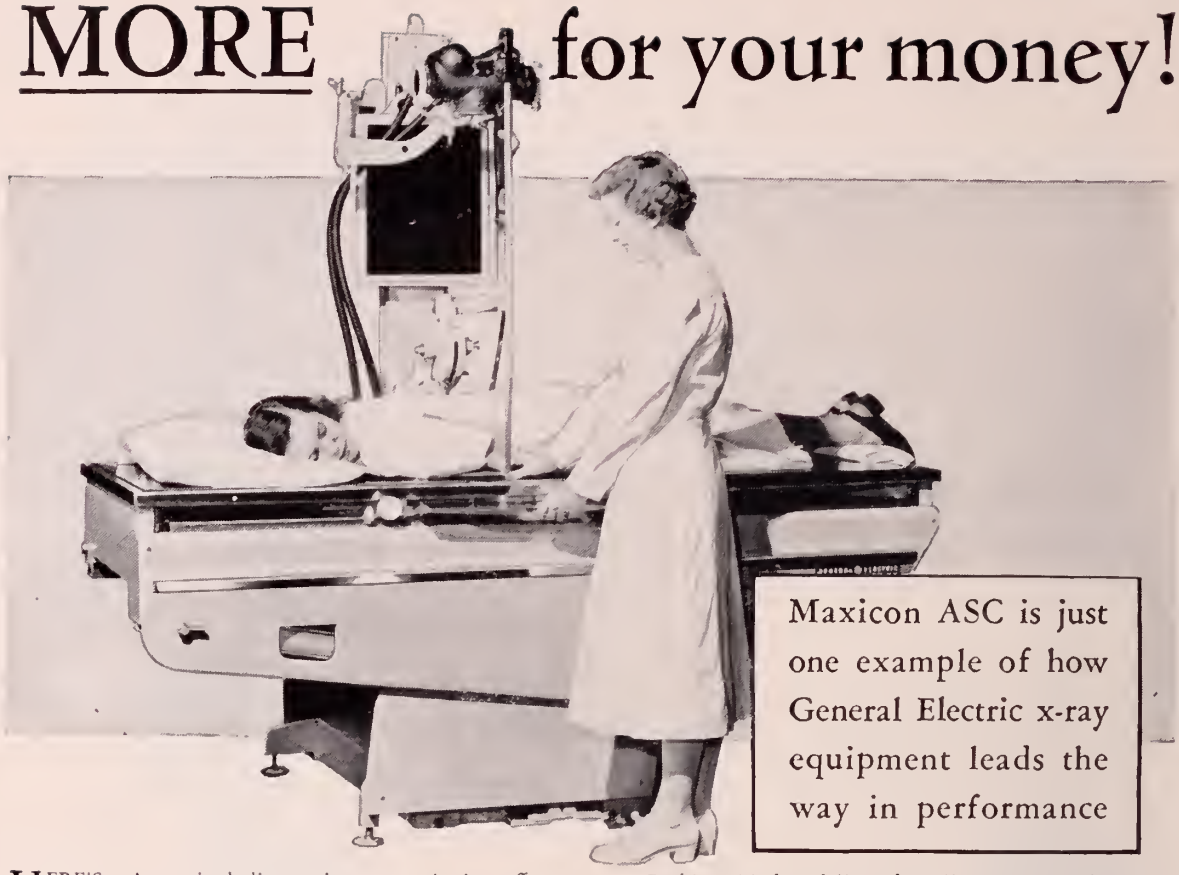
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The Preferred Vaginal Approach to Gynecologic Diagnosis and Therapy

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Surgeons possess a freedom of choice between the abdominal and vaginal approach in dealing with the surgery of pelvic disease. There is a definite trend in this country to increase the use of diagnostic and surgical approach to pelvic disease through the vaginal canal. This should be viewed as real progress. The desire of the physician should always be to rid the woman of all her troubles by the safest, least painful and least disfiguring method and, if possible, by one operative procedure. There is no question but that certain procedures in gynecology should be carried out through laparotomy and others through the vagina. The proper selection of patients is essential for the best results.

It has been recognized for many years that urologic diagnosis through the urethra is one of the most accurate and satisfactory methods of any specialty. Major pathologic growths and diseases of the urinary tract are being removed and treated through the urethra, which is a much smaller canal than the vagina. The vaginal canal can likewise be used for more accurate diagnosis and for the removal and treatment of major pelvic disease, all to great advantage and satisfaction both to the patient and to the physician.

There was a time, and unfortunately there still is today in some quarters, when the surgeon suggests to the patient that he will perform a laparotomy and "sort of look around and see what is necessary to be done" rather than carry out a meticulous preoperative diagnostic study. This approach requires less mental and physical effort and is less time-consuming for him. To cap the climax, when no significant pathologic change is found, the same surgeon will then proceed with an appendectomy and perform some "piddling" surgery upon the ovaries, tubes, or uterus. Such procedures as puncture and resection of physiologic cysts or suspension of the uterus and ovaries are carried out to justify the laparotomy. The following is an example: A 38 year old white married Para 3-0-3 recently consulted us complaining of intermittent attacks of left lower quadrant abdominal pain associated with a low grade fever, gaseous formation and occasional passage of bloody mucus from the rectum, of two years' duration. Seven months prior to her visit to us and 17 months after the onset of her trouble, she had undergone a pelvic laparotomy. She told us the surgeon had told her that she had a "six-in-one" operation — namely, an appendectomy, excision of cysts from both ovaries, bilateral ligation of tubes, suspension of the uterus, and hemorrhoidectomy. We remarked that she had received a lot of surgery for her money. She replied, "I did, doctor, but I still have my trouble!" She was found to have diverticulitis of the sigmoid.

We consider the vaginal diagnostic and therapeutic methods to be described as versatile and proved effective weapons intended to relieve the woman of her pelvic disease by safe, relatively painless, and less disfiguring procedures. One does not have to be a magician; there is nothing in the methods beyond the scope of ordinary ability. We contend that the vaginal approach should be utilized by more gynecologists and that it

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should be extended by those who are already employing it.

We shall describe first the diagnostic methods and secondly the therapeutic procedures through the vagina. It should be emphasized that many of the diagnostic procedures permit therapeutic operations at the same time.

Diagnostic Methods Through the Vagina

1. DILATATION AND CURETTAGE. — This is a well established diagnostic and at times therapeutic procedure that needs no clarification.

2. POSTERIOR COLPOTOMY AND OCCASIONALLY ANTERIOR COLPOTOMY. — Sufficient operative space can be secured through a posterior colpotomy incision for accurate diagnostic and therapeutic procedures. If wider visualization becomes necessary or, as frequently happens, if therapeutic procedures are indicated, additional space may be obtained by stretching the angles of the incision or by primary ligation and cutting of the uterosacral ligaments. During closure of the incision, these ligaments are reattached to their normal positions. The uterus, if not fixed, may be rotated in all axes and may even be delivered into the vagina for careful inspection. With the posterior delivery of the fundus uteri the supports of the adnexa can be grasped and the tubes and ovaries delivered one at a time into the vagina. Complete visualization of the cul-de-sac, peritoneum, a portion of the sigmoid colon, small bowel and occasionally a low-lying cecum with the appendix can be obtained.

We are performing more and more posterior colpotomies. We find posterior colpotomy most satisfactory for accurate diagnoses. Valuable therapeutic operations may be performed at any time during the procedure.

3. COLPOSCOPIC, CULDOSCOPIC AND HYSTEROSCOPIC EXAMINATIONS. — We have had only a slight experience with these procedures, but surely these examinations will be employed with increasing frequency as more experience is obtained. Culdoscopic examination is being found especially useful in confirming our impression of Stein-Leventhal ovaries. The hysteroscope was recently most helpful in diagnosing a large fundal endometrial polyp, which had been missed in two previous curettages for postmenopausal bleeding.

4. HYSTEROSALPINGOGRAPHY. — This study is universally employed in sterility surveys, but may be most helpful in diagnosing congenital anomalies of the uterus, submucous myomas, large endometrial polyps, tuberculosis and tumors of the tubes, advanced abdominal pregnancies, and other abnormalities.

Therapeutic Methods Through the Vagina

1. VAGINAL HYSTERECTOMY. — In our clinic we are becoming more and more convinced that when a hysterectomy is indicated, the vaginal removal is to be preferred unless contraindicated.

The fundamental contraindications to vaginal hysterectomy are conditions which obviously would increase the risk over abdominal removal or the presence of additional intra-abdominal disease requiring a laparotomy. The size, position, mobility and accessibility of pelvic lesions are so variable that no indication or contraindication should be considered unchangeable. The size of the uterus may not be a contraindication because its bulk may safely be reduced by morcellation. A small fibromyoma situated beneath the bladder or between the leaves of the broad ligament may greatly interfere with removal because of danger to the bladder or with safe ligation of the uterine vessels. Endometriosis, chronic pelvic infection, and diverticulitis of the colon may produce such fixation that the abdominal route is indicated. Generally, we have not used the vaginal approach for removal of malignant disease of the cervix, corpus, or adnexa. Ovarian tumors of large size associated with uterine pathologic change usually contraindicate vaginal hysterectomy. Smaller and benign ovarian cysts, such as dermoids, simple cystomas and chocolate cysts, may be safely removed following hysterectomy. A posterior colpotomy, one of the first steps in our vaginal hysterectomy technic, will often disclose not only the nature of the adnexal swelling, but also the removability of the adnexal lesion. We recall one patient in whom a neoplasm of the left tube was found at the time of planned vaginal hysterectomy. The approach was then abdominal, and a fairly early carcinoma of the fallopian tube was removed. We do not believe that uterine suspension or previous pelvic surgery contraindicates the vaginal approach because of adhesions. Adhesions low in the pelvis can probably be better visualized and freed more easily through the vagina than from above. Nulliparity is not a contraindication.

Why do we prefer vaginal hysterectomy unless contraindicated? We are firmly convinced from our observations and from the observation of many others that when a hysterectomy is

indicated the vaginal route affords by far a lower mortality, a lower morbidity, and a better final surgical result than the abdominal approach. Atelectasis, pneumonia, and other pulmonary complications are less frequently encountered because there is no abdominal incision to splint the abdomen and to interfere with excursions of the diaphragm. There is less psychic trauma, especially in the younger and more fastidious women, with a concealed vaginal incision. Gas pains are likewise less severe. Postoperative adhesions, ileus, and intestinal obstruction are minimal. Thrombophlebitis and thromboembolism are much less common, probably because of decreased trauma to the large pelvic veins.

Most authors agree that poor operative risks are better handled by vaginal hysterectomy. If it is better for poor operative risks, should it not be safer and better for good operative risks? Ask the patient who has been subjected to both the abdominal and vaginal approach to removal of pelvic disease which route she would prefer. The reply is unanimous in favor of the vaginal operation.

We prefer vaginal hysterectomy to tubectomy for sterilization. We attempted to show in a discussion before the Gynecologic Section of the Southern Medical Association in Miami in November 1952 that the sole function of the uterus is childbearing. The uterus, although normal, is a potential liability after the childbearing is completed. Many examples were cited to show that the functionless organ may disturb the future health, happiness and even the pocketbook of a pair of parents. The best interests of the woman are served by a complete hysterectomy rather than a tubectomy.

We also believe that when a hysterectomy is indicated for intraepithelial carcinoma, and invasive carcinoma has been ruled out by study of the coned cervical biopsy specimen, a vaginal hysterectomy is the preferred procedure.

2. Vaginal Salpingectomy for Ruptured Tubal Pregnancy. — We employ posterior colpotomy in most patients to confirm or refute the suspected diagnosis of ruptured tubal pregnancy. It is ideal then to remove the involved tube through the same vaginal incision. If a hematocele is present, it is easily evacuated, and the uterus is delivered posteriorly into the vagina. The tube is then pulled down by traction on the utero-ovarian and upper broad ligament. Adhesions are usually easily freed by the finger or scissors. If it is impossible to deliver and excise the tube through the vaginal incision, nothing has been lost by the effort but a little time as the approach then is made through the abdominal route and the necessary surgery carried out.

3. Vaginal Removal of Small Benign Ovarian Growths. — Small dermoids, single or multiple benign cysts, small fibromas, and chocolate cysts can in many instances be removed by the posterior colpotomy route. Accurate visualization by manipulation is the key to success. The cure of ovarian malignant disease depends completely upon its early diagnosis. The delay caused by the patient's or the surgeon's contemplation of exploratory laparotomy may cost the patient her life. Women accept intravaginal exploration more readily because it leaves no visible scar and there is less pain postoperatively. If a diagnosis of ovarian malignant disease is then made, further and adequate therapy is carried out through the abdomen.

4. Plastic Repair of Cystourethrocele, Rectocele and Enterocele. — When the function of the uterus is no longer necessary, vaginal hysterectomy with coincidental attachment of the cardinal, uterosacral, and round ligaments, with additional anterior and posterior colporrhaphy is rapidly gaining favor everywhere. The results are most satisfactory with an especially low recurrence rate in contrast to the so-called "above and below" operations, or the British "round trip" procedures.

Summary

This discussion might more properly be entitled "judgment in gynecologic surgery." In dealing with the surgery of pelvic disease, we possess a freedom of choice between abdominal and vaginal approach. Certain procedures should most certainly be carried out through laparotomy and others through the vagina. The vaginal approach affords more accurate diagnosis and a safer and better final surgical result. There is a safety, a satisfaction, a pleasure, and a pride in these vaginal operations.

What we know about vaginal surgery has been derived, directly or indirectly, from others; especially the Presbyterian Hospital Staff of Chicago, Dr. A. D. Campbell of Montreal, and many other skilled pelvic surgeons in this country and

Europe whom we have had the privilege of observing.

The vaginal approach is "something better — a better deal" for the woman, and she certainly merits this. What do you think?

References

Allen, E.: Vaginal Approach to Gynecological Surgery, Surg. Clin. North America 33:193-207 (Feb.) 1953.

Counseller, V. S.: Vaginal Hysterectomy; Indications, Advantages, and Surgical Technic, Obst. and Gynec. 1:84-93 (Jan.) 1953.

Kennedy, J. W., and Campbell, A. D.: Vaginal Hysterectomy, Philadelphia, F. A. Davis Company, 1942.

Tyrone, C. H.: Total Hysterectomy, Vaginal or Abdominal, J. Louisiana M. Soc. 105:15-18 (Jan.) 1953.

A Statistical Analysis of One Hundred Eighty-One Consecutive Cases of Bronchogenic Carcinoma

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Carcinoma of the lung is protean in its behavior. It may cause symptoms that are produced by any disease causing impairment of pulmonary function. Unfortunately, when symptoms are present, the golden opportunity for curative resection has often passed. The lesion is of growing importance and yet remains one in which results are generally considered poor.

There follows a survey of cases of histologically proved bronchogenic carcinoma treated at the Veterans Administration Hospital, Richmond, Va., during the period July 1, 1946, to July 1, 1953. This is not a glowing report, but tends to follow the general picture set forth previously by many authors. We have attempted to analyze the results of treatment as observed at this hospital with an effort to explain why results are generally poor and what can be done by the medical profession to improve these results.

This report includes 181 cases of bronchogenic carcinoma. Cases diagnosed clinically and by roentgen examination without tissue confirmation have been excluded from this series. Of the 181 cases, the diagnosis was made elsewhere and thoracotomy carried out elsewhere in 3 cases.

These cases were diagnosed by bronchoscopic biopsy, biopsy of lymph nodes or other distant metastases, exploratory thoracotomy, and at autopsy. Table 1 depicts the morphologic type of tumors found and their incidence.

The diagnosis of bronchogenic carcinoma was relatively clearcut in 60 per cent of these cases. In 40 per cent the diagnosis was made at autopsy or exploratory thoracotomy. Table 2 demonstrates the methods of diagnosis and their general usefulness in this series.

Table 1.—Types of Malignant Tumors and Their Incidence

Type	Number	Percentage
Squamous cell	74	41.1
Adenocarcinoma	33	18.3
Undifferentiated	69	37.7
Alveolar cell	1	0.55
Not determined	4	2.20

Bronchoscopy was the most useful method of diagnosis. It was employed in 134 of the 181 cases and gave positive results in 72, or 53.7 per cent of the cases in which it was used.

Squamous cell lesions were present in 62.1 per cent, adenocarcinoma in 18.1 per cent, and undifferentiated lesions in 26.4 per cent. These figures tend to demonstrate the occurrence of squamous cell lesions in the larger order bronchi while the other two types occur more peripherally.

Diagnosis was made by biopsy of a lymph node, usually deep cervical, or by pleural fluid,

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or other distant metastases. These included 8.1 per cent of the squamous cell lesions, 21.2 per cent of the adenocarcinomas and 32.3 per cent of the undifferentiated carcinomas. These figures demonstrate the tendency toward early metastases in the more undifferentiated tumors.

In 26 cases, or 14.4 per cent of the series, the diagnosis was made at autopsy.

The diagnosis was made by thoracotomy in 46 cases, or 25 per cent of the total.

Table 2.—Methods of Diagnosis

	Percentage	Percentage of Types		
		Squamous Cell	Adenocarcinoma	Undifferentiated
Bronchoscopy	40.00	62.1	18.1	26.4
Distant metastases	20.55	8.1	21.2	32.3
Autopsy	14.45			
Exploratory thoracotomy	25.00			
Total	100.00			

Of the 181 cases, in 95, or 52.5 per cent, the lesions were totally inoperable at the time of diagnosis. In the remaining 86, or 47.5 per cent, the patients were subjected to thoracotomy. In 32, or 17.7 per cent, of these cases, the tumors were found to be nonresectable. Thus, 127, or 70.2 per cent, of the growths were inoperable and 54, or 29.8 per cent, were resectable.* A further survey of these cases revealed that in 43 of those in which the carcinoma was resected there was evidence of extension beyond the confines of the lung while in only 11 was the lesion localized to the lung.

Table 3.—Rate of Operability and Resectability

	Cases	Percentage
Total number of cases	181	100
Totally inoperable	95	52.5
Explored	86	47.5
Inoperable at exploration	32	17.7
Resected	54	29.8
Resected with extension	43	23.8
Resected without extension	11	6.0

Table 3 lists the rate of operability and resectability.

The resectability rate in this series is about the same as that reported in the literature. An analysis of 2,601 cases of carcinoma as reported in the literature[1-5] revealed that in 49 per cent of these cases the lesions were totally inoperable, in 48 per cent they were explored, and in only 26 per cent they were resected. In other words, in approximately half of the patients presenting themselves with carcinoma of the lung the lesion was totally inoperable, and in nearly half of the remainder it was found to be nonresectable at exploration. In our series resection with the maximum chance of cure, that is, in those cases with the carcinoma confined to the lung, was carried out in only 6.0 per cent of the cases.

This figure is extremely significant as it demonstrates the actual reason for the poor five year survival rate from this disease. The poor results are not shortcomings of surgery, but rather are shortcomings in knowledge and ability to diagnose this disease. Improvement in survival statistics will occur only with earlier diagnosis and earlier surgical extirpation.

Of these 181 cases, 140 have been followed through to fatal termination. In the remaining 41 cases, the patients are either still living or there is not adequate follow-up to list them as having died. Table 4 lists those with adequate follow-up who have died of the disease or from surgery.

Thus, in 106 cases in which the lesion was inoperable, symptoms had been present an average of 6.6 months at the time of diagnosis, and the over-all average life span was 10.4 months. In 34 cases with resection, in nearly all of which there was evidence of extension, the average time from onset of symptoms to resection was 9.4 months and to death was 19.4 months. These figures suggest that symptomatic bronchogenic carcinomas which can be resected are slower growing than those that prove to be inoperable. The exact causes for these facts are not known. One might surmise that tumor host relationship plays a part in these interesting findings.

In 46 cases, or 25 per cent, of this series the diagnosis was established by exploration. In addition, in another 15 cases exploration was carried out for lesions that could not be differenti-

*In 3 of these cases resection was performed elsewhere.

ated from carcinoma, but that proved to be benign. In 1 of these the patient underwent pneumonectomy for what was thought to be carcinoma, but proved to be blastomycosis. In many of these 46 cases all of the clinical and roentgen signs of cancer were present, but a positive diagnosis could not be made except by thoracotomy.

followed for an average of 16 months from the time of their discovery by roentgen examination until the time of surgery. By the time of surgery, 1 of these lesions was inoperable and 6 were clinically symptomatic or showed definite enlargement of the mass. Only 4 were explored in the absolutely silent phase. These 11 tumors thus rep-

Table 4.—Analysis of Cases Terminating Fatally

	Number of Cases	Average Time from Onset of Symptoms to Diagnosis	Average Time from Onset of Symptoms to Death
Inoperable	106	6.6 mos.	10.4 mos.
		Average Time from Onset of Symptoms to Resection	Average Time from Onset of Symptoms to Death of Those Surviving Surgery
Resectable	34	9.4 mos.	19.4 mos.

Of these 61 cases in which the diagnosis was established by exploration there were only 9 with silent, round, circumscribed lesions between 1 and 5 cm. in diameter as described by Storey, Grant and Rothmann.[6] Four, or 44 per cent, of these were malignant and 5, or 56 per cent, were benign.

These lesions are listed in table 5.

Table 5.—Coin Lesions

Silent, Discrete, Circumscribed Lesions 1 to 5 cm. in Diameter		
Number of Cases	Pathologic Diagnosis	Percentage
3	Undifferentiated carcinoma	33
1	Adenocarcinoma	11
4	Total malignant lesions	44
3	Granulomatous lesions (tbc)	33
1	Old lung infarct	11
1	Hamartoma	11
5	Total benign lesions	55

It is believed that by limiting the so-called coin lesions to small, solitary, circumscribed, asymptomatic, peripheral pulmonary lesions a better evaluation of these lesions can be made. Storey, Grant and Rothmann[6] reported an incidence of 17.5 per cent malignant tumors in 40 such consecutive coin lesions.

In these 196 cases of benign and malignant lesions, there were 20 that were discovered during the silent phase. Of these, 5 were benign and 15 were malignant. Among the 15 malignant lesions there were 11 peripheral discrete lesions, 3 hilar lesions and 1 infiltrative lesion. These 11 silent discrete peripheral malignant lesions were resent an important group. They are the ones that Overholt[7] stated are always resectable and that 75 per cent are resected with a chance of a cure. They also tend to demonstrate how long the silent phase is in some of these tumors. It is unfortunate that the patients were not operated upon at a much earlier date. Three of the 4 who were subjected to operation while the lesion was silent are living 50, 26, and 12 months postoperatively, respectively, without signs of recurrence. Of the other 7, 6 underwent resection of the tumor, and only 1 of that group is still living. This outcome demonstrates the low survival rate associated with bronchogenic carcinomas that are producing symptoms.

In 127 of the 181 cases of carcinoma, the lesion was found to be inoperable. In this group 106 of the patients were followed until the time of their death, averaging 10.4 months from the onset of symptoms. Twenty were lost to follow-up and are presumed to be dead or include those in whom the diagnosis was made recently and who are still living. There was 1, a white man who was subjected to exploratory thoracotomy on Oct. 31, 1951 and was found to have a nonresectable squamous cell lesion. He was given high voltage roentgen therapy with considerable improvement. He was last seen on Aug. 6, 1953, at which time he was gaining weight and doing well. A roentgenogram of the chest showed slight regression in the size of the tumor.

There were 54 cases in which the carcinoma was resected. In 3 of these cases the resection was performed elsewhere, and one was a tracheal resection. There were thus 50 cases in which re-

section was performed here specifically for carcinoma of the lung. In 33 of these 50 cases the patients are known to have died of their disease. These 33 include the operative and postoperative deaths in this series. Of the remaining 17 cases, in 1 the patient committed suicide 17 months after pneumonectomy, at which time he showed no evidence of recurrence, and in 3 the patients are living 11, 18, and 22 months since resection with evidence of recurrence. In 13, the patients are still living without evidence of recurrence. Three of these cases in which resection has been performed within the past six months, are not statistically significant. In the remaining 10 cases the period of time since resection varies from 9 to 53 months with an average follow-up of 28 months.

This series covers only seven years and is thus of no value in computing a five year survival rate. It does demonstrate conclusively though that the over-all five year survival in this series is extremely low, probably in the neighborhood of 2 to 5 per cent.

Only 11 of the cases in which resection was performed failed to show evidence of extension beyond the confines of the lung. The patients in 4, or 36 per cent, of these 11 cases are now among the 10 survivors mentioned.

Of these resections, 46 were pneumonectomies, 1 was a pneumonectomy with en bloc resection of the chest wall, 2 were lobectomies, and one was a lobectomy with en bloc resection of the chest wall.

There were 11 operative or postoperative deaths, giving an operative mortality of 22.2 per cent. It is noteworthy that for the first half of this series the operative mortality was much higher than for the last half. In the last four years there have been 2 deaths in 28 resections, or a mortality of 7.1 per cent. Reduction in operative mortality seems to be related to a better selection of cases for surgery, improved anesthesia, and a better understanding of the problems of fluid therapy and blood volume in the preoperative and postoperative periods. It should be pointed out that although the operative mortality in those patients undergoing resection for carcinoma is high, the same does not hold true for exploratory procedure or resection of lesions which prove to be benign. There was no operative death in the 15 cases of resection for undiagnosed nonmalignant lesions. In the literature the operative mortality for such resection is usually reported as being in the neighborhood of 1 per cent.

Discussion

This series is reported in order to bring out the poor survival figures seen in an institution where there are excellent diagnostic facilities and trained thoracic surgeons and thoracic surgical residents. The discussion of such a series should evolve around the reasons for the poor results, and possible methods of improving these results.

An analysis of this series reveals that in 52.5 per cent of the cases the lesion was totally inoperable at the time of diagnosis and that in 47.5 per cent the patient was subjected to thoracotomy, with the lesion being resectable in only 29.9 per cent. Of the 54 cases in which resection was carried out, in only 11, or 6.0 per cent of the total group, was there no evidence of extension.

How could this large number of cases in which the lesion was nonresectable, making up 70 per cent of this series, have been reduced? First, it could have been done by rendering the profession more conscious that cancer of the lung is the most common visceral tumor in men past 40 years of age and that any persistent respiratory symptom in this group is a danger signal worthy of investigation by roentgen examination of the chest. Just as important is the promotion of more extensive surveys by the various health departments and by industry. If such films are read by an expert with a high index of suspicion for pathologic change, many lesions will be detected at an early stage.

One of the weaknesses of this system is that when lesions are picked up in the silent phase, there often is a tendency on the part of both physician and patient to procrastinate and follow the lesion with serial roentgenograms. These watchers must be educated and thus eliminated. That such practices are prevalent is well demonstrated in this series in that there were 15 silent lesions which subsequently proved to be cancers, and of this group only 4 were operated on in the absolutely silent phase. Eleven of these were silent, undiagnosed, peripheral tumors, there being an average delay of 16 months from the time of their discovery by survey film until the time of surgery. It seems almost unbelievable that this type of procrastination could have persisted for so long. In 1 case the patient was a physician who followed his pulmonary lesion for 50 months before he consented to thoracotomy, and at that

time only a palliative pneumonectomy could be performed. Despite this average delay of 16 months, in 10 of these 11 cases the carcinoma was resectable, although in only 4 was the tumor still confined to the lung. This long delay demonstrates how long the silent phase may be and that when most cancers are diagnosed, they are much more advanced than this group. Ninety-one per cent of the lesions in these 11 cases were resectable as compared to 29 per cent in the total group.

If such reasoning is correct, it seems justifiable to say that a roentgenogram of the chest every six months in patients in the cancer age would demonstrate most of these lesions while asymptomatic or silent.

Rigler, O'Loughlin and Tucker[8] demonstrated that many bronchogenic carcinomas have a prolonged silent phase. They stated that some lesions could be seen when they attained a size of 3 mm. By studying, in retrospect, roentgenograms of patients in whom bronchogenic carcinoma subsequently developed they found minimal roentgen signs had been present for 7.8 months before symptoms began in the inoperable group and for 17 months in the operable group.

The importance of increased use of exploratory thoracotomy cannot be overemphasized as a means of reducing the number of nonresectable lesions of the lung. This paper supports numerous reports in the literature emphasizing this point. It has been found that the vast majority of the undiagnosed lesions which prove to be benign on exploration are best treated by resection. Of the lesions in the 15 such cases in this study, 2 were bronchial adenoma, a definitely malignant or potentially malignant lesion, 1 hamartoma, 1 blastomycosis, 2 lung abscess, 1 bronchiectasis, and 7 granulomatous, chiefly tuberculous. Resectional surgery is the generally accepted treatment for all of these lesions. In only 1 case, that of an old infarct of the lung, was resection carried out without benefit to the patient. The advantages of exploratory thoracotomy in those cases in which the lesion proves to be malignant are obvious. It is believed that in the same way the exploratory procedures for undiagnosed abdominal conditions has served to reduce the mortality from appendicitis, perforated peptic ulcer, and other conditions, the increased use of exploratory thoracotomy should serve to reduce the mortality from carcinoma of the lung.

Failure on the part of both physician and patient to grasp the importance and significance of abnormal pulmonary symptoms plays an important part in producing the poor results of treatment of this disease. When symptoms develop or abnormal roentgen findings are present, the problem should be handled with a degree of urgency. Diagnostic procedures, including exploratory thoracotomy, should be carried out within a period of days rather than months. In over 100 cases in this series in which the lesions were found to be inoperable, the duration of disease from onset of symptoms to death was only 10.4 months. It is hardly surprising that these lesions were inoperable when the diagnosis was delayed an average of 6.6 months, well over one half the duration of the disease after the onset of symptoms.

Although the end results of treatment of carcinoma of the lung generally have been poor, we believe that there is no justification for the defeatist attitude so often shared by patient, physician, and surgeon. In the literature there are reports that 31 to 44 per cent of those patients surviving surgery were living and well five years after resection. In this series approximately a third of the patients surviving surgery are living without evidence of recurrence 9 to 53 months following resection. As experience with carcinoma of the lung broadens, the over-all results surely should improve.

Conclusion

Cancer of the lung is a common malignant disease in men past 40 years of age.

There is a prolonged silent phase, usually accompanied by roentgen signs, before symptoms begin.

Resectability rate and cure are directly related to diagnosis and resection during this silent period.

There is a relatively low resectability rate and cure rate in patients who are having symptoms from cancer of the lung.

Survey films are the most useful method for detecting these lesions while silent.

Men over 40 years of age should have a roentgenogram of the chest every six months if improvement in resectability rate is to be attained.

Once a lesion is detected its true nature should be determined without delay.

The development of any new or unusual pulmonary symptoms justifies immediate and thorough investigation.

The exploratory operation should be utilized for diagnosis of lesions that cannot be diagnosed by other methods.

The results of the surgical treatment of carcinoma of the lung justify an aggressive approach to this disease.

A series of 181 cases of bronchogenic carcinoma is analyzed.

References

1. Lindskog, G. E.: Bronchiogenic Carcinoma, Ann. Surg. 124:666-674 (Oct.) 1946.
2. Bloomer, W. E., and Lindskog, G. E.: Bronchiogenic Carcinoma; Report Comparing 3 Consecutive Series of 100 Cases Each, Cancer 4:1171-1175 (Nov.) 1951.
3. Churchill, E. D.; Sweet, R. H.; Soutter, L., and Scannell, J. G.: Surgical Management of Carcinoma of Lung; Study of Cases Treated at Massachusetts General Hospital from 1930 to 1950, J. Thoracic Surg. 20:349-358 (Sept.) 1950.
4. Allbritten, F. F. Jr.; Nealon, T.; Gibbon, J. H. Jr., and Templeton, J. Y. III: Diagnosis of Lung Cancer, Surg. Clin. North America 1657-1672 (Dec.) 1952.
5. Ochsner, A.; DeCamp, P. T.; DeBakey, M. E., and Ray, C. J.: Bronchogenic Carcinoma; Its Frequency, Diagnosis, and Early Treatment, J. A. M. A. 148:691-697 (March 1) 1952.
6. Storey, C. F.; Grant, R. A., and Rothmann, B. F.: Coin Lesions of Lung, Surg., Gynec. & Obst. 97:95-104 (July) 1953.
7. Overholt, R. H.: Cancer Detected in Surveys, Am. Rev. Tuberc. 62:491-500 (Nov.) 1950.
8. Rigler, L. G.; O'Loughlin, B. J., and Tucker, R. C.: Duration of Carcinoma of Lung, Dis. Chest 23:50-71 (Jan.) 1953.

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Discussion

Dr. Kenneth A. Morris, Jacksonville: I have had the opportunity to read Dr. Brown's paper. It represents careful study and a great deal of hard work. I hope that many of you who are interested in thoracic surgery will read this entire paper because you will find much meat in it. Because of the time allowed, Dr. Brown was able to stress only certain significant and important points. The fact that the lesion was resectable in but 30 per cent of the cases in which the patient was subjected to thoracotomy and that in only 6 per cent of these cases extension had not taken place is discouraging. It should be remembered, however, that during the past 20 years in which bronchogenic carcinoma has been attacked surgically, the five year survival rate is higher than that for carcinoma of the stomach, which has now been treated surgically for over 45 years. We should be able to diagnose bronchogenic carcinoma early in most cases. It is the only visceral malignant tumor that gives us a roentgen ray clue. When suspicious shadows are found, every means possible should be taken to make a diagnosis. If then one is not able to arrive at a diagnosis, exploration should be carried out immediately. As for procrastination, there are many ways in which this takes place. Sometimes the patient is responsible for the delay, and sometimes the doctors are responsible. As Dr. Brown has mentioned, especially is it dangerous to wait to see whether a shadow increases or decreases. I have been interested in thoracic surgery for probably about the past 18 years. We have found that one of the best ways to keep from making mistakes is by taking the time to sit down with the patient's physician and with the roentgenologist and have a conference in each case. I know that that is done in many places. Whenever we have neglected to do that and have gone ahead on our own at times, we have been sorry.

Dr. Brown has pointed out a number of ways in which these delays can be overcome, and it is hoped that in the next 10 years statistics such as these will show a better result. I should like to take this opportunity, after listening to Dr. Brown's paper and to Dr. Daughtry's and hearing Dr. Seiler talk, to say that the work being done by younger men than myself has far outstripped anything that we had hoped for. I see no reason in this state in the future for patients needing thoracic surgery or cardiac surgery to go out of the state. I have been interested in it only as a general surgeon, and it certainly has been a pleasure to me to hear these men talk.

Dr. DeWitt C. Daughtry, Miami: I should like to congratulate Dr. Brown upon presenting this excellent paper. This type of statistical analysis requires a great deal of time and is certainly the only way that we can tell just what we are accomplishing. I have been greatly interested in this paper ever since I heard that Dr. Brown was going to present it. I preceded Dr. Brown at the same institution and started off this series of cases. In fact, most of the long term follow-up cases were treated at the time I was there. I admit responsibility for some of the poor results. We had the usual difficulties in getting a large new service started. These statistics do look bad, but are comparable to those of other large series of cases. Practically all of our early cases were far advanced. In addition, our diagnostic and surgical team required training and organization. I should like to stress the fact that the resection rate was especially low early in the series because of the type of cases seen at that time. Our statistics are going to look better in the future for two reasons: First, we know better how to care for these patients from the standpoint of surgical and postoperative treatment. Secondly, we are seeing these patients at an earlier stage of their disease.

One distressing feature which will be a little difficult to correct is the delay in getting the patient to the surgeon. Two persons are responsible for this delay; one is the patient, and the other is the physician. The patient's delay is only half as long as the delay between the time the patient goes to his family doctor and the time he reaches the surgeon. We must not permit this situation to continue. All should realize that cough, wheezing, hemoptysis and chest pain must be thoroughly investigated. There is no excuse for taking a roentgenogram and just watching the lesion progress. We have to do something about it when we see a lesion. It should indicate an all-out attack. In other words, do not just take a roentgenogram and tell the patient you will see him again in three months and see how the lesion looks by that time. Also, do not send in specimens of sputums for cytologic study and do nothing else. There has been much delay in that regard in the past two or three years. This test is important, but it is just a part of the investigational work-up. Let us remember that a definite tissue diagnosis can be made in only about 50 per cent of the cases. If a definite diagnosis cannot be made and one's clinical impression is that carcinoma exists, the patient must be operated upon without undue delay. Seldom will the experienced physician be mistaken. It is much easier, in my estimation, to make a diagnosis of carcinoma of the lung than of many other lesions which are readily operated upon when the least suspicion of malignant disease exists.

I hope there is a real educational lesson in the three slides to be shown. The first slide shows a small left hilar lesion. The appearance of this roentgenogram plus cough, mild wheezing, hemoptysis and the loss of 15 pounds in weight seems most significant. We note, however, from slide 2 that nothing was done and this roentgenogram four months later shows considerable increase in the size of the left hilar infiltration. The patient was told that he had something suspicious in his lung, and six months later, or after ten months had elapsed from the time the first roentgenogram was taken, we see on slide 3 a great increase in the size of the infiltration, which now involves about one third of the left lung. By this time the physician apparently became rather alarmed and sent the patient to a thoracic surgeon, who found that the lesion was hopelessly unresectable and thus incurable. How can we improve our statistics when a good percentage of each 100 cases that reach the surgeon falls into this category?

DR. BROWN, concluding: I wish to thank Dr. Morris and Dr. Daughtry for their discussions. I would like to add one thought as to how we can make the diagnosis of this disease earlier. The only plan I have to suggest is not used in this state, but I have seen it used elsewhere. In some of the large and highly industrialized states in the northern part of the country the industrial commissions of the states require routine roentgenograms of the chest on all persons who work in industry. These survey films are repeated once a year. Under this plan not only is carcinoma picked up early, but tuberculosis is also discovered at an early date.

Aneurysms and Arteriovenous Fistulas of the Peripheral Vascular System

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Historically, aneurysms and arteriovenous fistulas have always been of keen interest to physicians and have been subjected to much study. Their onset is frequently dramatic, the result of arterial trauma. In the case of arteriovenous fistulas physiologic effects are profound. Both may cause death, fistulas by progressive heart failure and bacterial endocarditis, aneurysms by rupture. These lesions must therefore be vigorously treated. Fortunately in most instances in modern times, due to the brilliant endeavors of Matas and his successors, their cure can be realized through surgery. Developments in this field have been rapid during the past few years, primarily the result of added case material following two wars in rapid succession. This report is concerned with the present day approach to the problems afforded by these vascular fistulas and aneurysms and their surgery as illustrated by a few unusual clinical examples.

Aneurysms

Aneurysms arise most frequently in the peripheral arterial system as a result of trauma or the degenerative effects of advanced arteriosclerosis. Naturally, in examining a patient with a large pulsating mass the thought that the lesion is of arterial origin should always be entertained in differential diagnosis. In the case of peripheral aneurysms of the extremities and even of the abdominal aorta, auscultation not infrequently will disclose a "purring" systolic murmur, and a thrill can also be palpated. Pressure on the lesion will often stem the bruit and thrill. In lesions within the chest such diagnostic signs are usually not present, and here the diagnosis is made considerably more difficult. In most lesions angiography is diagnostic and should be performed in those cases in which surgery is considered. Kymography may give additional data as to the nature of obscure thoracic aneurysms when angiography is not utilized.

Having established the diagnosis, the clinician faces the problem of whether or not surgery should be advocated for these lesions. In general, age and severe debility are the only factors precluding, or rendering debatable, surgical attack in these conditions. Aneurysms should be energetically treated by surgery when possible. In the aged, special consideration may prevail in view of the limited life expectancy. Here too though, even if surgery is deemed "risky," one must balance the danger with the risks if a definitive operation is not performed. In this sense there is the possibility of thrombosis of old aneurysms of the extremities with resultant development of gangrene. This catastrophe is most likely to occur in popliteal aneurysms, and less likely in more centrally located lesions. Other factors, too, must be considered in assessing any particular aneurysm. For example, one must consider the nature of the aneurysmal wall, that is, whether thick, calcified or thin, the stability of the lesion over recent months, and the closeness to major collateral trunks as demonstrated by angiography, as well as the patient's general condition and life expectancy. Likewise, the proximity to major nerve trunks and the degree of symptoms are factors of importance in reaching a decision as to therapy.

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The location, as previously intimated, is of vast importance, as aneurysms of the abdominal aorta may rupture, while those of the popliteal artery may thrombose. One must consider all these factors seriously before reaching a decision as to whether or not surgery should be performed, and as to the extent of surgery.

In instances involving nerve trunks neurologic evaluation should be made prior to surgery, and in some instances surgery should be performed in conjunction with a neurosurgeon.

The extent and location of collateral circulation are all important in determining the type of therapy. A number of tests have been devised to evaluate this, particularly when the aneurysm has been occluded. Generally speaking, these tests are applicable only to the extremities. In the estimation of Shumacker,[1] the Matas reactive hyperemia test is most reliable and practical. In this procedure a blood pressure cuff is placed about the limb above the aneurysm. The leg is then elevated and emptied of blood. The blood pressure cuff is inflated to 220 mm. of mercury and the extremity lowered. Blanching of the extremity is now observed. After four minutes the aneurysm is compressed, the blood pressure cuff deflated rapidly and the extremity examined for the presence of a flush. This should be seen within two minutes if collateral circulation is adequate.

Angiography is of considerable value in locating important collateral vessels. Urokon sodium or Diodrast is usually employed as a contrast medium; however, in the aged Thorotrast also has merit. The percutaneous route will usually suffice in administration of the medium. Interpretation of the roentgenograms necessarily involves knowledge of vessel anatomy and the technic of arteriography.

In some peripheral lesions daily compression of the aneurysm for increasing periods of time has been useful in adding to the collateral circulation. As a rule though, if three[2] to six months have transpired since injury, collateral circulation is adequate; this, however, may not be true in all areas of the body. The final assessment of adequacy of collateral circulation must in all instances be made at the operating table.

If in the treatment of peripheral aneurysms collateral circulation is found wanting prior to surgery, sympathectomy has been advocated.[3] In most cases reconstitution of the arterial circuit is desirable and in some necessary. This has been attempted by endoaneurysmorrhaphy as outlined by Matas,[4] and by bridging the aneurysmal defect with a vein graft.[5] It may not be possible to perform these procedures in all instances.

If possible the aneurysmal sac is removed at surgery. In many cases though, due to proximity of important structures, or fear of compromising collateral vessels, the sac is left in situ. The arterial defect is corrected from within the opened sac by ligation or suture of the main arterial and collateral openings. This maneuver is one of the most frequent measures employed in the treatment of aneurysms and generally is successful in curing the lesion. It allows for a useful extremity in most instances.

Aneurysms of the thoracic aorta, if saccular, may be treated by excision, or aneurysmorrhaphy, through the intact sac.[6] The aorta is repaired by suture of the lateral vessel wall, or by application of a previously obtained aortic homograft. In many instances wiring will afford palliation.

Aneurysms of the abdominal aorta may be treated surgically, particularly when of saccular nature.[6] In most instances cases amenable to surgery will be ones with lesions below the superior mesenteric artery. The vessel wall may be repaired, or replaced by a homograft.

For the most part, the use of Cellophane[7] to produce a fibrous reaction on the surface of the aneurysm has not met with general acceptance. Diacetyl phosphate injection[2] and plastic sponge application[8] have been suggested, too, as sclerosing methods to toughen the wall of the aneurysm.

The following case is presented to illustrate some of the features of surgical treatment of aneurysms:

Case 1. — A Negro man, aged 26, was admitted to Mount Sinai Hospital in January 1953. He stated that he had been stabbed in the left shoulder about a year previously and since then a large swelling had developed in the left shoulder and chest (fig. 1). His left arm became progressively numb and cold. Examination showed a mass involving the entire axilla with the clavicle elevated. A soft systolic murmur was present over the mass. A wrist pulse was not obtainable, but a good one was noted on the right side. An arteriogram showed an intact though depressed axillary artery. A venogram ended abruptly at the tumor, but blood coursed peripherally. Aspiration of the mass revealed clotted blood.

A diagnosis of aneurysm was made, and exploration was performed. The subclavian artery and vein were first isolated above the clavicle for controlling bleeding from the axillary artery distally. The incision was then carried down into the axilla and onto the arm. The pectoralis major muscle and portions of the pectoralis minor over the aneurysm were divided. An attempt was made to dissect free the thin-walled massive aneurysmal sac, but this was soon entered. It was then quickly opened along its entire length, and about 1,500 cc. of clotted blood was removed. This constituted the "false" aneurysm, and the "true" aneurysmal outpocketing of the

artery was found at the upper, chest-wall end of the "false" sac (fig. 2). Bleeding was brisk from the arterial openings, but was controlled first by packing and then by isolation and suture of the openings. The aneurysm was in a proximal portion of the axillary artery and did not appear on the arteriogram because of the laminated clot. All tissues were allowed to collapse inward, and the wound was sutured. As seen six months later, the chest wall on the left was similar to that on the right, and arm function was excellent, though a pulse was still not obtainable. The patient is now back at work as a laborer.



Fig. 1. — Preoperative view in case 1 showing bulging aneurysm of left axillary artery.

Arteriovenous Fistulas

Arteriovenous fistulas may or may not be associated with aneurysms. They almost invariably form in adults as the result of trauma to an adjacent artery and vein. They may be of congenital origin. The effect of an arteriovenous fistula on the circulation is profound. Cardiac changes result with enlargement and progressive failure. Bacterial endocarditis and valvulitis may likewise ensue. The closer to the heart, and the larger the fistula, the greater the effects of the shunting of blood.[9]

Clinically, these lesions can be diagnosed by the history of injury, the not infrequently associated aneurysmal tumefaction, and the presence of a thrill systolic and diastolic in time. This latter sound is loud and continuous.

In all cases the lesions should be treated surgically, though a limited number have closed spontaneously. Here, too, as in the surgery of aneurysms the extent and location of collateral circulation must be assessed preoperatively and at operation. The testing is similar to that in evaluating aneurysms. An adequate collateral is usually present if three to six months is allowed to elapse from the time of injury to surgical repair of the fistula.[10]

The procedure usually employed in surgical repair of these lesions is excision of the fistula with quadruple ligature involving the artery and vein immediately proximal and distal to the fistula. Suture of the vessel openings from within the frequently associated aneurysmal sac may be employed. Ligature of the venous openings and lateral arteriorrhaphy may be used by the transvenous approach. Present thinking would seemingly indicate that, when possible, the vascular circuit should be reconstructed.[5] This procedure may be essential in some, but generally is not necessary for limb viability and adequate function. Venous reconstitution is usually not advocated, though it has been employed in a limited number of cases.

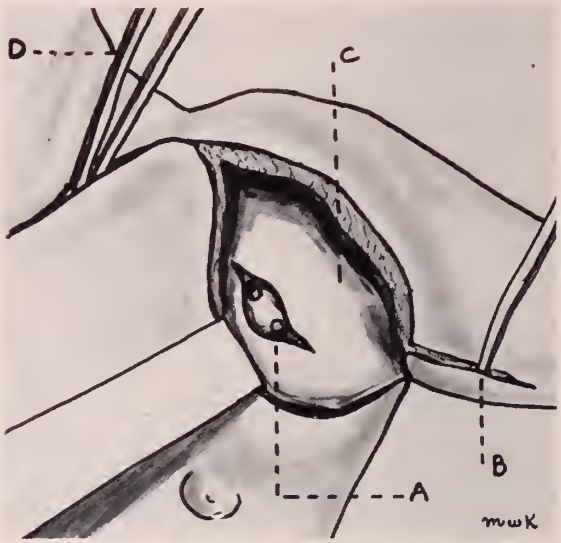


Fig. 2. — Operative field showing: (A) Aneurysm of axillary artery with proximal and distal arterial openings. (B) Tape about brachial vessels. (C) "False" aneurysmal sac with clot removed. (D) Tapes about subclavian artery and vein.

The following clinical case is illustrative of some of the features and problems of arteriovenous fistula repair:

Case 2. — A 24 year old white male prisoner of the Stateville Penitentiary, Joliet, Ill., had been shot in the left lower portion of the abdomen a year and a half previously. Subsequently, a small mass developed in the area, which presented all the signs of an arteriovenous fistula involving the external iliac vessels. Cardiac enlargement was observed on roentgenography. Oscillometric pulsations were diminished in the affected leg. Collateral circulation was deemed adequate, based on the rapidity of the leg flush following release of artery compression. Accordingly, surgical correction of the fistula was attempted.

The lesion was approached through a long incision over the pubic ligament extending down the upper leg. Muscular structures of the abdomen were reflected upward after transection of the internal oblique and transversus muscles. This procedure exposed the retroperitoneum to the level of the internal iliac branchings. The fistula with its aneurysmally enlarged vein lay in the midportion of the external iliac vessels (fig. 3A). The artery below the fistula was small.

The artery and vein were isolated above and below the fistula, and umbilical tapes were passed around the artery. These were attached to lung tourniquet clamps for control of blood flow through this vessel. The vein above and below the fistula was ligated. A transvenous exploration then was performed with the artery temporarily occluded. Collateral venous channels were suture-ligated from within the vessel, and suture arteriorrhaphy was performed on the fistulous opening into the artery. The adjacent wall of the vein was excised and the wound closed.

Summary

Modern day concepts of the treatment of aneurysms and arteriovenous fistulas of the peripheral arterial system are reviewed. In general these lesions should be treated surgically and can be corrected by proper use of a variety of available procedures. It is essential to evaluate the status of collateral circulation before repairing the defects, and in some reconstitution of the previously damaged vessels may be necessary to maintain limb function. Two cases are presented to illustrate respectively arterial aneurysm and arteriovenous fistula repair, and some of the problems coped with in their successful surgical treatment.

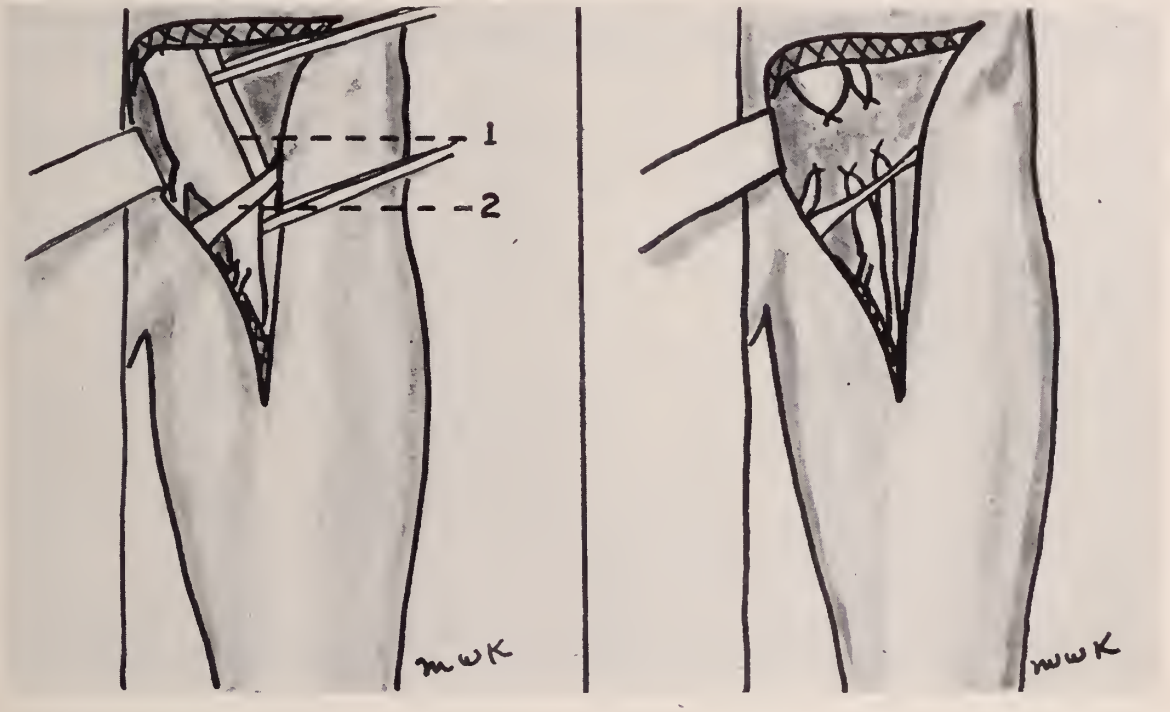


Fig. 3.—Operative field in case 2 showing: (A) Arteriovenous fistula of left external iliac artery and vein with (1) site of fistula and (2) Poupart's ligament. (B) Quadruple ligation, ligature of collateral vein and excision of fistula completed.

Healing was good until the twelfth postoperative day, when a hematoma developed in the wound. Since it was believed that this represented a blow-out of the sutured fibrotic fistula opening in the artery, the wound was reopened. A hematoma was evacuated and the artery ligated immediately above and below the point of previous arteriorrhaphy. This latter area was then excised, and Gelfoam was used to control capillary oozing (fig. 3B). Peripheral circulation was not disturbed by this turn to the conventional form of arteriovenous fistula repair by quadruple ligature, and excision of the fistula. Recovery was uneventful except for cotton suture extrusion. The patient had good function of the limb a year later when last seen, and the cardiac silhouette had returned toward normal.

The author wishes to acknowledge the valuable assistance rendered by Dr. J. R. Rickles in case 1, and by Drs. L. R. Rubenstein and J. Venckus in case 2.

References

1. Shumacker, H. B. Jr., and Carter, K. L.: Tests for Collateral Circulation in Extremities, Arch. Surg. 53:359-377 (Oct.) 1946.
2. Berman, J. K.: Principles and Practice of Surgery, St. Louis, C. V. Mosby Company, 1950.
3. Shumacker, H. B. Jr.: Sympathectomy as Adjuvant in Operative Treatment of Aneurysms and Arteriovenous Fistulas; Sympathectomy Performed Before or at Time of Operation, Surgery 22:571-596 (Oct.) 1947.
4. Matas, R.: Surgery of the Vascular System, in Keen, W. W., editor: Surgery. Its Principles and Practice, Vol. V, Philadelphia, W. B. Saunders Co., 1920.

5. Shumacker, H. B. Jr.: Problem of Maintaining Continuity of Artery in Surgery of Aneurysms and Arteriovenous Fistulae; Notes on Development and Clinical Application of Methods of Arterial Suture, Ann. Surg. 127: 207-230 (Feb.) 1948
6. Bahnson, H. T.: Excision of Aortic Aneurysms, Maryland M. J. 2:537-546 (Oct.) 1953.
7. Poppe, J. K., and Renault de Oliveira, H.: Treatment of Syphilitic Aneurysms by Cellophane Wrapping, J. Thoracic Surg. 15:180-195 (June) 1946.
8. Grindlay, J. H., and Waugh, J. M.: Plastic Sponge Which Acts as Framework for Living Tissue; Experimental Studies and Preliminary Report of Use to Reinforce Abdominal Aneurysms, A. M. A. Arch. Surg. 63:288-297 (Sept.) 1951.
9. Matas, R.: On Systemic or Cardiovascular Effects of Arteriovenous Fistulae. A General Discussion Based Upon the Author's Surgical Experience, Tr. South S. A. 36:623-681, 1924.
10. Pemberton, J. DeJ., and Waugh, J. M.: Traumatic Arteriovenous Aneurysm; Report of 11 Cases, S. Clin. North America 19:981-1001 (Aug.) 1939.

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Infectious Mononucleosis in Infants and Children

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Infectious mononucleosis, commonly known as glandular fever, has been accepted traditionally as a disease of young adults. Prior to the presentation of this report, medical literature contained only a few reports of cases of infectious mononucleosis in children as verified by clinical, hematologic and serologic data. In this paper we shall describe 32 cases of infectious mononucleosis in infants and children as observed in our private practice of pediatrics during the past few years. Among these cases are represented all the bizarre manifestations, cerebral, hepatic, intestinal, cardiac, pulmonary and renal, which heretofore have been regarded as rare complications in adults suffering from this disease. Indeed, we have encountered infectious mononucleosis with such constancy in our private and consultative practice that we must conclude that this disease occurs with startling frequency among the citizenry, and particularly the children, of central Florida.

Historical Background

Turck[1] in 1907 first made mention of a lymphocytic blood reaction associated with angina and sepsis although Pfeiffer[2] in 1889 had described the clinical entity in children which he called glandular fever. Burns[3] in 1909 initially associated lymphocytosis up to 70 per cent in clinically recognized glandular fever. Deussing[4] was first to report lymphocytosis occurring with glandular fever in children.

In 1923 Downey, for whom is named the atypical lymphocyte that may be one of the hematologic characteristics of infectious mononucleosis, and McKinlay[5] gave a clear cytologic description of the hematologic picture characterizing infectious mononucleosis. Finally, in 1932 the serologic criteria for diagnosis of this disease were set forth by Paul and Bunnell.[6] Recent reports of cases have been concerned primarily with descriptions of well identified cases of infectious mononucleosis in the adult based upon these established clinical, hematologic and serologic findings. These reports emphasize the extremely protean nature of the disease and enumerate its involvement of nearly every organ of the body.

Etiology

Leibowitz,[7] in his recently published monograph, concluded cautiously that "in infectious mononucleosis it is possible that the as yet unidentified etiologic agent, presumably a virus, contains an antigenic component which stimulates the production of these (heterophile) antibodies."

Diagnosis

It was the presence of these antibodies in significant titer (over 1:64) in the serum of patients presenting clinical and hematologic findings highly suggestive of infectious mononucleosis that confirmed the diagnosis of infectious mononucleosis in the present series.

A titer of 1:64 or even 1:112, in the absence of significant clinical and hematologic findings, cannot be accepted as diagnostic without confirmatory absorption studies.

It is only during the past nine months that laboratory facilities for performing the Davidsohn absorption technic have become locally available. Since in only 7 of the cases in this series was this technic employed, all serums tested giving a strongly positive reaction, we shall reserve discussion of these and more recent cases for a future report.

Clinical Considerations

General. — The 32 patients were successively encountered in pediatric practice between July 1951 and May 1954. They included 8 infants under 2 years of age and 24 children under 14 years of age. Of these, 2 were Negroes. Nineteen of these patients were met in the eight month interval from October 1953 to May 1954, which gives this series a definite seasonal weight and, coupled with observations of other practitioners in this area, might conceivably represent a regional incidence over this period of near epidemic proportions.

In all but 6 cases a satisfactory follow-up examination was recorded so that it was thus possible to estimate with fair accuracy the duration of clinical symptoms in this age group.

Table 1. — Frequency of Presenting Complaints

Presenting Complaint	Number of Patients
1. Fever	22
2. Sore throat	10
3. Swollen glands (cervical)	7
4. Rash	5
5. Leg aches or joint pains	5
6. Vomiting	5
7. Convulsion	4
8. Stiff neck or headache	4

The distribution obtained when each case was classified under its predominant presenting complaints is shown in table 1. There was of necessity some overlapping of symptoms and signs such as fever, present in 70 per cent of the cases, sore throat in 30 per cent, glandular swelling in 22 per cent, rash or joint pains in 15 per cent, vomiting in 15 per cent, and convulsions or stiff neck in 12 per cent.

The more important clinical manifestations of infectious mononucleosis have been abstracted from the case records and are presented in table 2. In 11 instances clinical findings at the onset of illness or subsequent complications were severe enough to warrant hospitalization of the patient for an average period of five and a half days.

Table 2. — Significant Clinical Findings

Physical Finding	Number of Patients
1. Generalized lymphadenopathy	16
2. Enlarged tonsils	13
3. Meningismus	9
4. Rash	7
5. Splenomegaly	6
6. Atypical pneumonia	4
7. Limitation of joint motion	3
8. Jaundice	2
9. Peripheral edema	1

In table 3 cases are summarized in order of chronologic age with data assembled showing the mode of clinical onset, hematologic findings, and significant serologic titer recorded during the course of the illness. Early in the series the services of four recognized laboratories were utilized with the unavoidable result that this table records heterophile titers in several different dilution patterns.

Initial Complaints. — Fever, soreness of the throat and swelling of the cervical glands represent the three presenting complaints most commonly encountered in infectious mononucleosis during infancy and childhood. In our experience the appearance of the tonsils and posterior pharynx may be highly suggestive of the diagnosis. In 13 of the 32 cases the clinical picture was that of pale, markedly enlarged tonsils appearing boggy in their consistency and, in 7 cases, containing in their crypts a caseous white exudate. Cultures of the exudate produced a wide variety of pathogenic organisms. Possibly these contributed to the complications which occurred in about half of the cases during the course of the illness. The pharynx not infrequently was studded with edematous, hyperplastic lymphoid tissue of a peculiar translucency, described by Ziegler[8] as mucoid blisters.

In the 6 cases most closely resembling the classical description of glandular fever, sore throat and fever were of abrupt onset and were followed in a matter of hours by the appearance of walnut-sized anterior cervical nodes which were firm and somewhat tender. Following vigorous therapy, these nodes usually diminished in extent so that in a week's time they were of peanut size.

Generalized Lymphadenopathy. — In half of the cases generalized lymphadenopathy occurred during the course of the disease, usually at the end of five or seven days of illness.

Table 3. — Case Summaries of Infectious Mononucleosis in 32 Infants and Children

Case	Age (years)	Presenting Complaints	Complications	Hematologic Studies					Hetero-phile Titer	Duration (months)
				White Blood Cell Count	Polymor-phonu-clears	Lymph-ocytes	Eosin-ophils	Per Cent Downey		
1-HB	8/12	Sore throat, fever, rash		11,000	30	68	—	25	1:160	Continuing
2-DG	10/12	Swollen glands, cloudy urine		8,800	10	88	2	—	1:64	3
3-LK	1	Vomiting, diarrhea, stiff neck	Dehydration	4,450	17	80	3	10	1:224	1
4-JL	1	Convulsion, fever, rash		10,150	54	46	—	40	1:360	3½
5-JH	1 3/12	Vomiting, fever, stiff neck		9,800	33	63	—	4	1:120	2
6-BS	1 3/12	Convulsion, fever	Pneumonia	4,000	30	70	—	15	1:64	1½
7-KW	1 3/12	Convulsion, fever, rash		6,450	33	66	1	60	1:120	2½
8-JC	1 11/12	Vomiting, fever, rash	"Nephritis"	15,650	61	37	2	—	1:360	2¼
9-JW	2 2/12	Convulsion, fever, swollen glands		12,200	49	41	10	—	1:360	3
10-ID	2 5/12	Cough, fever, swollen glands		9,550	25	71	—	2	1:120	¾
11-RB	2 7/12	Sore throat, rash		6,300	12	84	4	—	1:64	2½
12-LI	2 8/12	Chills, fever	"Pyelitis"	7,050	42	57	1	—	1:120	3
13-KP	2 8/12	Rash, fever		7,500	23	74	1	5	1:160	4½
14-WM	2 9/12	Rash, sore throat, fever, edema	"Nephritis"	5,100	60	40	—	—	1:320	¾
15-JX	3 9/12	Sore throat, fever, swollen glands	Atypical pneumonia	8,450	41	58	1	60	1:160	1
16-DH	4	Drowsiness, headache, fever	Otitis media	14,900	36	62	2	—	1:64	1½
17-AP	4 3/12	Loss of appetite, anemia		9,400	36	58	4	20	1:320	Not known
18-AS	4 4/12	Sore throat, fever		3,300	13	70	4	20	1:120	1½
19-BM	4 5/12	Pain in right thigh, fever		5,800	18	78	4	—	1:64	2½
20-JB	5 3/12	Fever, fatigue		3,800	41	59	—	—	1:224	1½
21-PS	5 8/12	Stiff neck, headache, rash		7,300	46	42	1	14	1:160	3½
22-SR	6	Sore throat, leg aches, fever	Pneumonia	9,550	35	59	6	—	1:448	Not known
23-WS	6 2/12	Swollen glands		6,600	38	49	7	6	1:64	4½
24-MS	6 3/12	Sore throat, joint pains, fever		8,200	32	66	—	2	1:126	Not known
25-RW	6 3/12	Fever, pallor, swollen glands	Anemia	3,900	27	73	—	15	1:160	2
26-LC	7 2/12	Stiff neck, vomiting, abdominal pain		4,750	43	55	2	—	1:112	2
27-JP	8	Fever, swollen glands, anorexia		10,600	66	31	3	—	1:320	Not known
28-HC	8 1/12	Drowsiness, vomiting, stiff neck	Atypical pneumonia	3,150	39	51	2	—	1:112	½
29-KD	10 3/12	Fever, swollen glands	Hepatitis	9,000	46	54	—	—	1:160	Continuing
30-RS	10 11/12	Headache, abdominal pain, rash	Hepatitis	2,200	21	70	—	10	1:896	1½
31-LF	11	Sore throat, fever		4,200	27	61	—	2	1:64	6
32-JD	11 11/12	Leg pains	Anemia	6,000	48	50	2	—	1:160	1

Other Clinical Manifestations. — A rash was observed at one time or another in the course of the infection in 7 cases. It usually was transitory, and morbilliform or scarlatiniform in appearance. Most frequently it presented palely over the trunk though in 1 case it involved briefly only the upper arm and in another its distribution was limited to the posterior auricular and malar areas. We considered such spotty distribution of the rash to be most helpful in differentiation of this infection from the common communicable diseases of infancy and childhood.

A palpable spleen was noted in only 6 cases despite the high incidence of generalized lymphadenopathy in this age group. Its appearance was not apparently related to the presence of enlarged cervical nodes, elevated blood count, or fulminating clinical course of the illness.

Bizarre Complications. — In 4 cases convulsions with or without significant elevation of temperature were the presenting complaint. Although spinal fluid pleocytosis did not occur in these cases, we have observed in consultation 1 case of infectious mononucleosis in an older child in which a severe meningoencephalitis ensued, with moderate lymphocytosis of the spinal fluid.

In 2 cases the patients were jaundiced at the time of their first office visit. Both children, though they initially appeared acutely ill, responded satisfactorily within two weeks to a general supportive regimen including bed rest in the home. Although the high incidence of hepatic involvement, estimated to occur in 85 per cent of the cases of this disease in adults, was cited in 1953 by Leibowitz,[7] no liver function studies were made in this series.

In 1 case in which the patient was hospitalized, there developed a carditis which at the time was believed to be of rheumatic origin. Subsequent acquaintance with carditis as a rare manifestation of infectious mononucleosis in the adult has led us in reviewing the history of this case to conclude that the pancarditis present was but another clinical variant of this diversiform disease.

In 3 cases there developed what was believed at first to be a pyelitis accompanied by high fever. Repeated urinalyses, however, disclosed only occasional white and red blood cells and a trace of albumin. The specimens of urine were uniformly cloudy and contained many mucus threads and much epithelial debris. Culture revealed the urine to be sterile. One such "nephritic" complication was accompanied by a typical morbilliform rash on the infant's face, which faded as the renal involvement subsided.

Two cases, requiring hospitalization of the patient, were unique in that the presenting complaint was diarrhea of an explosive and prostrating nature, for which no bacteriologic cause was detected. In the younger patient a confirmatory guinea pig absorption test, high lymphocytosis in the peripheral blood, and generalized lymphadenopathy, with subsequent appearance of the typical rash on the trunk, seemed to justify the diagnosis. A recent article by Walker[9] directed attention to severe diarrhea as a complication of infectious mononucleosis in the newborn.

Hematologic Studies. — It should be noted that, in general, the white blood cell count tended to be normal or reduced early in the illness and rose after the second week to a fairly high level. The atypical (Downey or abnormal) lymphocyte, whose appearance in the peripheral blood once was regarded as pathognomonic of infectious mononucleosis, is highly suggestive of, but by no means specific for, this disease. Certainly its presence in the blood of children should not be relied upon in arriving at a diagnosis since it occurred in only 17 cases in this series.

Although our follow-up studies are not complete in this respect, it was concluded that in general the observation that in adults a significant eosinophilia occurs in the convalescent stage of infectious mononucleosis appertains in infants and children.

Anemia was rarely observed during the acute phase of the illness, although in 3 of our cases in which symptoms were of several weeks' duration, anemia and fatigability were the presenting complaints.

Serologic Technic. — The modified Paul-Bunnell sheep cell agglutination test was employed in all cases. A positive titer was accepted as 1:64 or higher. In 4 cases requiring hospitalization of the patient in which there were low titers early in the illness, and in 3 of the complicated cases, confirmatory titers after absorption with guinea pig kidney were obtained.

Differential Diagnosis. — In practice, the differential diagnosis in the "typical" cases is usually made in a child suffering from sore throat whose febrile episodes recur over a period of two or more weeks. In a good number of the older children who complained of leg aches and tiring easily it was necessary to exclude rheumatic fever. In such cases a significant serologic titer is often

the essential differential factor, since the sedimentation rate as well as the white blood cell count may be markedly elevated in the early stages of mononucleosis that is complicated by an intercurrent infection.

Perhaps the most outstanding lesson to be learned from this presentation is the importance of distinguishing a convulsive seizure denoting the onset of fulminating infectious mononucleosis from a simple febrile convulsive episode. In such cases a generalized lymphadenopathy and a pronounced peripheral blood lymphocytosis without elevation of the white blood cell count may serve as important clues in determining the true etiology of a sustained convulsive seizure in an infant or child.

Infectious mononucleosis appears to be as important a cause of jaundice among children as it has recently been noted to be in adults by Schultz and Hall.[10] In determining its presence in the differential diagnosis of hepatitis, one should employ both heterophile and absorption serologic technics.

Treatment

In treatment of our early cases all possible combinations of chemotherapeutic and antibiotic agents were used with no appreciable effect upon the course of the disease.

During the past six months, however, we have noted a gratifying response in approximately 75 per cent of the cases in which we have prescribed oxytetracycline (Terramycin) in high dosage (100 to 120 mg. per kilogram of body weight). In complicated cases in which we have recently employed intramuscular Terramycin, we have noted several dramatic responses. Before this intramuscular preparation became generally available, we had observed several infants who tolerated the oral administration of the drug so poorly that its use was of necessity discontinued. It is our practice to administer in addition sulfadiazine or penicillin with streptomycin during the course of treatment in an attempt to eliminate from the upper part of the respiratory tract those secondarily invading organisms so often present on throat culture in these cases.

Summary

A series of 32 cases of confirmed infectious mononucleosis occurring in infants and children dwelling in central Florida is reported and analyzed. The protean nature of this disease and certain unusual complications are described. Clinical, hematologic and serologic criteria for the differential diagnosis of glandular fever in this age group are presented.

Conclusions

1. In infants and children any sore throat which is accompanied by high fever and enlargement of the cervical glands of considerable degree should be regarded as possibly due to infectious mononucleosis until appropriate blood studies and serologic tests have been performed.

2. Infectious mononucleosis occurred with unusual frequency in this age group in our locale during the period covered by the series.

3. Bizarre manifestations of the disease affecting the cerebrum, heart, kidney, intestine, and hematopoietic and integumentary systems appear to be much more common in children than in adults afflicted with this disease.

4. Terramycin in high dosage produced significant remission or cure in about 75 per cent of the cases in this series in which the drug was employed.

References

1. Turck, W.: Septische Erkrankungen bei Verkummerung des Granulozytensystems, Wien. klin. Wchnschr. 20:157, 1907.
2. Pfeiffer, E.: Drusenfieber, Jahrh. f. Kinderh. 29:257, 1889.
3. Burns, J. E.: Glandular Fever; Report of an Epidemic in Children's Ward of Union Protestant Infirmary, Arch. Int. Med. 4:118-125, 1909.
4. Deussing, R.: Uber diphtherieahnliche Anginen mit lymphatischer Reaktion, Deutsche med. Wchnschr. 44:513 and 542, 1918.
5. Downey, H., and McKinlay, C. A.: Acute Lymphadenosis Compared with Acute Lymphatic Leukemia, Arch. Int. Med. 32:82-112 (July) 1923.
6. Paul, J. R., and Bunnell, W. W.: Presence of Heterophile Antibodies in Infectious Mononucleosis, Am. J. M. Sc. 183:90-104 (Jan.) 1932.
7. Leibowitz, S.: Infectious Mononucleosis, New York, Grune and Stratton, 1953.
8. Ziegler, E. F.: Infectious Mononucleosis; Report of Fatal Case with Autopsy, Arch. Path. 37:196-201 (March) 1944.
9. Walker, S. H.: Infectious Mononucleosis Manifested by Diarrhea, U. S. Armed Forces M. J. 2:1875-1878 (Dec.) 1951.
10. Schultz, A. L., and Hall, W. H.: Clinical Observations in 100 Cases of Infectious Mononucleosis and Results of Treatment With Penicillin and Aureomycin, Ann. Int. Med. 36:1498-1512 (June) 1952.

P.O. Box 1254.

1954 MEDICAL DISTRICT MEETINGS

"A" Marianna	October 11
"B" Sanford	October 13
"C" Sarasota	October 15
"D" Vero Beach	October 14

ABSTRACTS OF MEDICAL ARTICLES

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 1018, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

The Journal of the American Medical Association is limiting its Current Medical Literature section. Thus, our main source of information on articles written by our members has been greatly curtailed.

Mental Retardation. By William L. Musser, M.D. South M. J. 47:77-79 (Jan.) 1954.

This paper presents current facts and attitudes regarding the incidence of mental retardation and outlines an approach to the problem of the mentally retarded child. It is noted that a conservative estimate indicates that an average of one out of 50 births today results in a mentally retarded child. Furthermore, hereditary causes are responsible in less than half of the cases, the great majority in the author's opinion being due to causes which are possibly preventable or whose incidence could continually be reduced.

Mental retardation is not simply a matter of retarded or low intelligence, but rather a complex sociobiologic problem about which the physician should be adequately informed for he is an important factor in creating either a completely hopeless situation or a sane and rational understanding. State or private institutions, many of which are ugly monuments to ignorance and complacency, are commonly advised, but it is rather amazing to the author that seldom is any thought given to advising that the child be kept at home for a while. Before it is advised that all mentally retarded children should be institutionalized at birth, there should be investigation into the characteristics of the home, the nature and availability of a proper institution, and the degree of retardation in the child. In his plea for assistance in giving the lives of these "crippled" children some meaning, he stresses an urgent need for more modern hospital schools operated at a state level to care adequately for many retarded children, but adds with equal insistence that each community eventually has to realize that many of these children can be kept at home, and educational and recreational facilities should be provided by that community. The brightest sign on the horizon in this field at present, he finds, is the formation of certain parent groups throughout the country which have united to form the National Association for Retarded Children.

Trichophyton Rubrum Infection Simulating Erythema Perstans. By Morris Waisman, M.D. J. Invest. Dermat. 22:237-241 (March) 1954.

It is the purpose of this paper to direct attention to infrequent fixed urticarial and erythematous manifestations of infection of the skin with Trichophyton rubrum, which may simulate eruptions described under various names as chronic and atypical varieties of erythema multiforme. This uncommon circinate and gyrate urticarial eruption caused by this organism is clinically indistinguishable from the chronic variant of erythema multiforme known as erythema perstans. The absence of scaling in these lesions may unfortunately divert clinical suspicion from their mycotic origin. It is suggested that intensive search for fungi is required in such cases because of the paucity of organisms, perhaps due to immunologic factors of the patient. Even during remissions of the eruption it may be possible to demonstrate the "silent" presence of T. rubrum in the area, accounting for the fixed recurrences of lesions. Four illustrative cases are presented.

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Medical District Meetings
October 11-15, 1954

Dr. Francis H. Langley of St. Petersburg, chairman of Council, has announced that the programs for the four Medical District Meetings have been completed. These programs, scheduled for October 11, 13, 14 and 15, have been arranged by Dr. Langley with the assistance of the eight councilors. In charge of arrangements for the meetings are: Northwest District, Dr. George S. Palmer, Tallahassee, assisted by Dr. James T. Cook Jr., Marianna; Northeast District, Dr. Henry J. Babers Jr., Gainesville, assisted by Dr. Terry Bird, Sanford; Southwest District, Dr. Clyde O. Anderson, St. Petersburg, assisted by Dr. Lloyd J. Duest, Sarasota; and Southeast District, Dr. Russell B. Carson, Fort Lauderdale, assisted by Dr. Vernon L. Fromang, Vero Beach.

Medical District Meetings are designed so that Association officers and members may meet with a minimum of travel and so that doctors will be away from their practices for only a short time. The scientific portion of the program at each meeting has been planned to be sufficiently diversified to be of interest and value to the general practitioner and specialist alike. The programs this year will be in the form of panel discussions on subjects met daily in most doctors' offices.

Following the scientific program, officers of the Association will present pertinent and interesting information at each of the meetings. Association officers and committee chairmen who will speak include Drs. Duncan T. McEwan, President; John D. Milton, President-Elect; Samuel M. Day, Secretary-Treasurer; Shaler Richardson, Editor of The Journal; H. Phillip Hampton, Chairman, Committee on Legislation and Public Policy, and Edward Jelks, Public Relations Liaison to Board of Governors. The general sessions will be in charge of Dr. Langley, assisted by a councilor from each district as follows: Marianna, Dr. George S. Palmer of Tallahassee; Sanford, Dr. Thomas C. Kenaston of Cocoa; Vero Beach, Dr. James R. Sory of West Palm Beach; and Sarasota, Dr. Clyde O. Anderson of St. Petersburg.

The session in Marianna will begin at 3:30 p.m. on October 11. At 6:45 refreshments will be served followed by dinner at 7:30. In the other three Districts the sessions will begin at 2:30 p.m. on the days indicated on the program below. Refreshments will be served by the host societies at 5:45, and dinner will follow at 6:30. Printed programs will be mailed to all members of the Association prior to the meetings.

Woman's Auxiliary Workshops will be held in connection with the District Meetings. Every doctor's wife is urged to attend these informal sessions. Mrs. William D. Rogers, Chattahoochee, third vice president of the Auxiliary, will conduct the meeting in Marianna on October 11; Mrs. Albert G. Love IV, Gainesville, first vice president, will preside at the meeting in Sanford on October 13; Mrs. Charles McD. Harris Jr., Lakeland, second vice president, will be in charge of the workshop in Vero Beach on October 14; and Mrs. John P. Ferrell, St. Petersburg, fourth vice president, will conduct the meeting in Sarasota on October 15.

Scientific Assemblies — Four Medical Districts

Monday, October 11, 1954
3:30 p.m.

Marianna — A

Graham Air Base

Presiding: Francis H. Langley, Chairman of Council, and William P. Hixon, Councilor of District 1.

Address of Welcome, Jabe A. Breland, President, Jackson-Calhoun County Medical Society.

Panel Discussion — Common Emergencies.

Surgical, Sidney G. Kennedy Jr., Pensacola; Obstetric and Gynecologic, William C. Fontaine, Panama City; Medical, Barkley Beidleman, Pensacola; Pediatric, Alvyn W. White, Pensacola.

Thursday, October 14, 1954
2:30 p.m.

Vero Beach — D

Ocean Grill

Presiding, Francis H. Langley and Russell B. Carson, Councilor of District 8.

Address of Welcome, William L. Fitts 3rd, President, Indian River County Medical Society.

Panel Discussion — Business Office Management.

Laurie R. Teasdale, West Palm Beach; Lees M. Schadel Jr., Fort Lauderdale, and M. Jay Flipse, Miami.

Wednesday, October 13, 1954
2:30 p.m.

Sanford — B

Mayfair Inn

Presiding: Francis H. Langley and Henry J. Babers Jr., Councilor of District 3.

Address of Welcome, J. Clifford Boyce, President, Seminole County Medical Society.

Panel Discussion — Office Procedure.

Urology, Truett H. Frazier, Orlando; Gynecology, Edward P. Madden, Daytona Beach; Laboratory, Leila H. Wells, Jacksonville, Use of Hydrocortone, Alva T. Cobb Jr., Gainesville.

Friday, October 15, 1954
2:30 p.m.

Sarasota — C

Sarasota Bay Country Club

Presiding, Francis H. Langley and James R. Boulware Jr., Councilor of District 6.

Address of Welcome, Henry J. Vomacka, President, Sarasota County Medical Society.

Panel Discussions — N. Worth Gable, St. Petersburg, Moderator.

Heart Problems, Jere W. Annis, Lakeland; Minor Surgery, C. Frank Chunn, Tampa; Gynecology, Woodrow B. Estes, St. Petersburg; Laboratory and Office Management, Luverne H. Domeier, St. Petersburg.

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The Journal of the Florida Medical Association

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William Beaumont Memorial

One of the truly great sagas of medical progress was fittingly commemorated on July 17, 1954. The occasion was the dedication of a memorial to a Connecticut farm boy, turned physician's apprentice, who earned a medical certificate without benefit of medical school and in addition won everlasting fame for his discoveries in the physiology of digestion. The physicians of Michigan have every right to be proud of their role in recreating the site of the fateful shooting in 1822 which led William Beaumont, young American army surgeon stationed in a wilderness outpost on Mackinac Island, to take advantage of the accident and make one of the greatest contributions to scientific medicine. Behind the dedication of the Beaumont Memorial lies a decade of dreams, plans and work by Michigan doctors of medicine. Consummation of the project now brings to them the praise, the appreciation and the congratulations of their colleagues across the nation.

Built and furnished in authentic style through individual contributions from members of the medical profession, the memorial is a reconstruction of the original American Fur Company store, adjacent to old Fort Michilimackinac where the accidental shooting took place. The larger of the two rooms in the building houses a museum containing writings, paintings and other mementos of Dr. Beaumont. The smaller room represents a retail store exhibiting the type of merchandise sold in a frontier outpost of the early nineteenth century. The Beaumont Memorial is in historic Mackinac Island State Park, which is geographically the center of most of the important activities of the early Northwest Territory. In accepting the memorial to Dr. Beaumont, tendered as a gift from the Michigan State Medical Society, the people of Michigan share with their physicians the privilege of honoring their pioneer citizen whose work symbolizes medical progress through research. Together, they pay homage to a man who typifies the traditionally high standards of the medical profession in this country — the devoted medical practitioner, the tireless research worker, the heroic army doctor, and, in later life, the skilled medical teacher.

The Beaumont story is probably as familiar to school children as to doctors. Perhaps it was sheer coincidence that made Dr. Beaumont America's pioneer physiologist, or it may have been destiny

with a special flair for the dramatic. The only doctor in a vast wilderness, he fortunately was within earshot of the shooting of the hardy young French-Canadian voyageur, Alexis St. Martin, who survived the presumably fatal wound to become a medical curiosity, a man with a hole in his stomach. This patient with the gastric fistula afforded Dr. Beaumont the opportunity to observe the functions of the stomach and make the discoveries which gave the study of nutrition a foundation of proved facts. All the scientific aids developed since 1822 have revealed little more about the action of the stomach than he learned without a laboratory.

Despite little training and limited experience, Dr. Beaumont became a brilliant experimenter, indefatigable in pursuit of fact. He fed his patient through the mouth and through the gastric fistula. He studied the digestion of almost every kind of food, cooked, uncooked, whole, chopped, seasoned, and unseasoned. When Alexis grew surly, he observed the effect of emotion on digestion; when the youth overindulged in alcoholic drinks, he checked the reactions. In this crude setting, by his keen powers of observation he discovered the nature of gastric digestion and thereby benefited all mankind. In so doing, he fulfilled a cherished ideal, which he well expressed in these words: "Truth, like beauty, is when unadorned, adorned the most, and in prosecuting these experiments and inquiries, I believe I have been guided by its light."

On-Campus Study of Osteopathic Schools

The American Osteopathic Association, meeting in Toronto last July 15, gave its approval to direct on-campus observation and study of osteopathic schools by a committee of the American Medical Association for the purpose of determining the quality of medical education provided. This action comes as a result of the efforts of the Committee for the Study of Relations Between Osteopathy and Medicine, created in 1952 by the House of Delegates of the American Medical Association. At the June meeting of the American Medical Association in San Francisco this year, the committee submitted a progress report, later adopted, which took the position that "the justification or lack of justification of the 'cultist' appellation of modern osteopathic education could be settled with finality and to the satisfaction of most fair-minded individuals by direct on-campus observation and study of osteopathic schools." Permission to visit these schools for this purpose was requested and has now been granted.

The plan to observe the nature and scope of the educational programs of the schools probably will be carried out this fall. It provides that two members of the A.M.A. committee, accompanied by a person of established experience in inspection of medical schools, visit each school and conduct studies of sufficient duration, breadth and depth to determine the extent and the quality of the medical education provided.

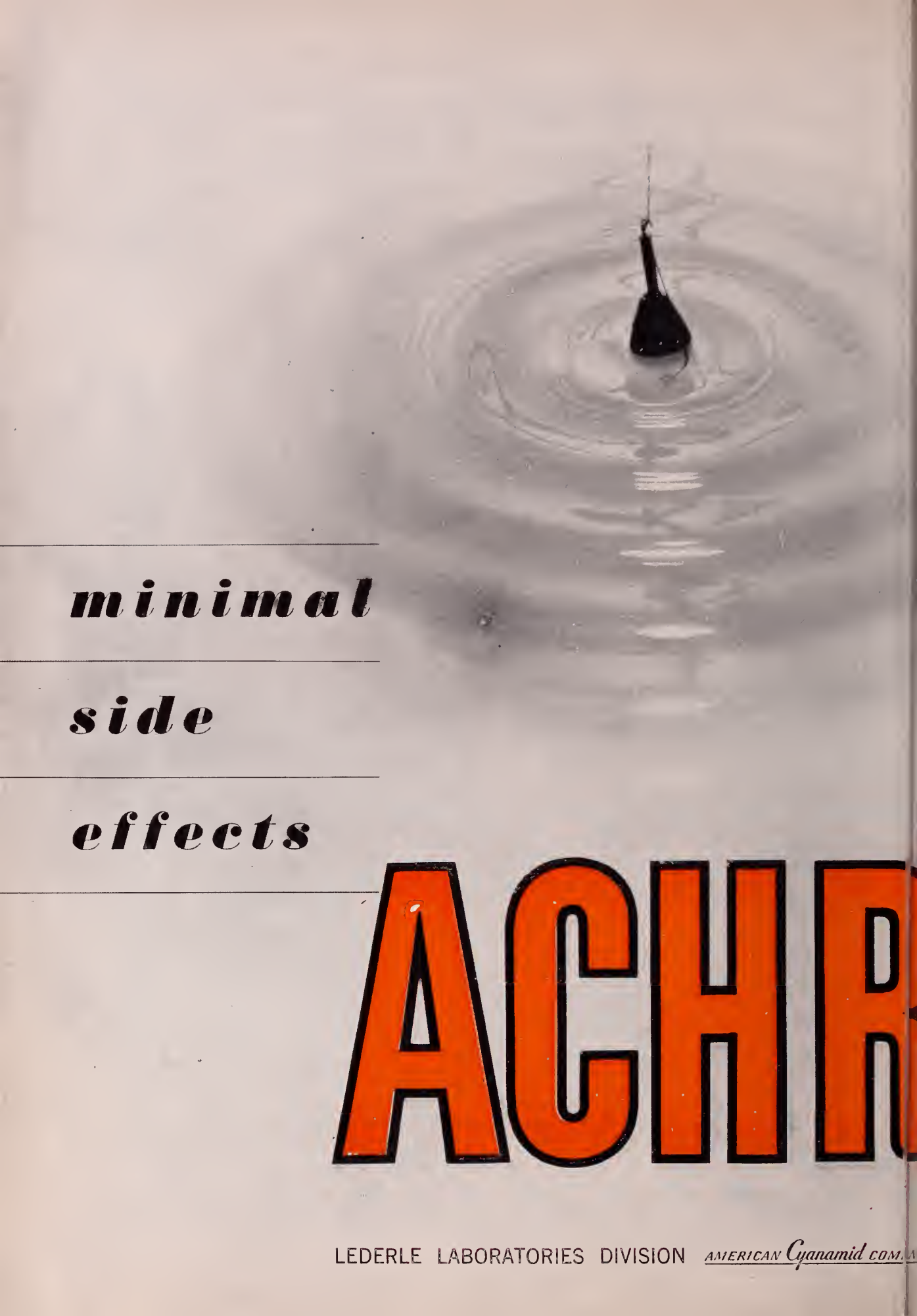
In a statement on the favorable action by its House of Delegates, the American Osteopathic Association defined the immediate purpose of the on-campus visitations as providing information to the A.M.A. committee "to assist in its efforts to remove the cultist designation from the osteopathic profession." It also declared that the observational opportunity accorded this private agency to determine for itself osteopathic programs and procedures was in keeping with its long-indicated willingness to cooperate with the authorized group of any profession "wherever that cooperation may be expected to improve the health service offered the public." In commenting on the action, John W. Mulford, D. O., of Cincinnati, the association's newly elected president, said it was taken "with the complete confidence that neither the osteopathic profession nor the medical profession wishes to inflict its officialdom on the other," and he added that the step could be considered as "a logical outgrowth of the mutual respect which the two schools of healing hold for each other."

British Labor Learns the Hard Way

"Is England Returning to the Private Practice of Medicine?" Under this title an editorial in the July 20 number of New York Medicine observed that British companies, like those in the United States, have to negotiate new contracts with labor unions and, as have those in this country, these companies have supplied so-called "fringe" benefits in the health and welfare field. Answering its own question as to the nature of these new fringe benefits in England, the editorial explains:

"They are prepaid medical insurance plans which make it possible for the workers to go to private physicians of their own free choice and have the plan pay the costs of medical care. . . .

(Continued on page 294)



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(Continued from page 291)

"Human nature being what it is, we now have the situation where the reaction has set in and the British workers prefer not to go to the National Health Service. The workers prefer to go to their own private doctors. They want free choice.

"The trouble is that they did not realize this until they surrendered their free choice. Now the unions find that they have to negotiate to get it back."

British labor is having to learn the hard way, but apparently is coming around to the viewpoint of Sir Arthur Porritt, Fellow of the Royal College of Surgeons. "Never," said he, "have we more needed to stress the human side of medicine, the individual contact, mental and physical, of patient and doctor, where the former has infinite trust and confidence in the latter and the latter gives unselfishly and freely of his best to the former. These things are intangibles, I fear, but they are pearls beyond price, worthy of tireless pursuit and strictest preservation. I do not feel that the palliative mediocrity of a state service begins to reach out towards them."

Herbert Hoover said it, in his West Branch, Iowa, speech the other day on the occasion of his eightieth birthday: "One of the post-war cousins of socialism is the so-called 'welfare state.' This poison gas is generated by fuzzy-minded intellectuals. Its slogan is 'planned economy.' The phrase itself was borrowed from totalitarian governments. The end of it would at least be a government wherein whatever is not forbidden would be compulsory." Will it be said of this country, as it now may be said of Britain, that she did not appreciate the water till the well ran dry?

Touring A.M.A. Headquarters

The stalwart heart of American medicine is housed in a nine story granite building in downtown Chicago, a tour of which is both enlightening and otherwise rewarding. Here in the hub of the nation, the hub of medicine provides a gracious hostess to show the interested visitor the wheels of the American Medical Association in lively motion. As a shareholder in this largest and most powerful medical organization in the world, the visiting physician-member finds a beehive of medical activity essential to the progress of the profession and the safeguarding of the nation's health. He discovers some 900 workers performing their day-to-day duties in the name of more than 140,000 doctors, of whom he is one. Eleven unions are represented among the employees.

A printing and publishing plant occupies three floors and the basement. Printing costs alone run more than $4,000,000 a year. It is no wonder that about $15 of each member's $25 annual dues goes into the Journal of the American Medical Association, the editing and printing of which is the chief operation in this field. Also published here are nine medical specialty journals, scores of books, and thousands of booklets, pamphlets and reports. On the top floor, manuscripts are processed for publication in the various journals and the work on the Quarterly Cumulative Index Medicus goes forward. Here, too, a package library service is available on free loan to members from one of medicine's largest collections of periodicals and reference material.

In one office records are kept of every physician from the time he enters medical school to the day of his death. Periodically, these data are published in the association's Directory. The work, however, goes on constantly to keep this information up to date. It cost $341,000 last year to keep tabs on all the doctors in the United States. Contrary to opinion, doctors move around quite a bit, the guide reports, and it is difficult to keep up with some of them. The two cards on each physician filed and indexed here not only contain biographic data, but they also show what A.M.A. publications a doctor subscribes to, whether he is an A.M.A. member, and whether he has paid his dues. Besides serving to make up the Directory, these records may be used to identify quacks, to help call doctors for military service, and for various surveys. In addition, here in the Membership and Subscription Department are kept the circulation records for Today's Health, which, according to the guide, is the most widely read health magazine in America and "the only authentic one."

There is a mail room where some 30,000 pieces of incoming mail are handled each month. The outgoing mail, with a volume tremendously larger, is handled in a separate area. Over a million pieces of literature a year are mailed out by Today's Health alone. The building has its own postal inspector, and mail sacks are filled and handled in the basement. There also the Journal of the American Medical Association and all the specialty journals thunder through the huge four

color presses. There are 13 presses served by two shifts a day. The Journal is printed from Wednesday to Friday in sections of eight pages, which a machine automatically assembles into complete issues; the plates then are torn down, and it takes until the following Tuesday to set up the next week's issue.

The physician visiting the headquarters for the first time learns that almost 60 per cent of association revenue is expended on scientific activities. One floor houses extensive laboratories where tests are made mainly in three fields — chemistry, microbiology and physical medicine. New drugs are analyzed to check manufacturers' claims, and when approved, may bear the A.M.A. seal of approval. Foods, even cigarettes, are analyzed. Standards are set for makers of medical supplies to follow. Yearly reference books on drugs are published. A search is made for harmful ingredients in cosmetic items such as face powder, lipstick and hair oils. The health aspects and safety of pesticides are studied. Tests are made to determine whether hearing aids, respirators, diathermy machines and other mechanical devices can be rated acceptable.

The Bureau of Investigation has long rows of files on hundreds of illegal practitioners, peddlers of fake nostrums, faith healers, and quack machines. More than 3,000 inquiries a year are answered on such subjects as "reducing pills," "cures" for rheumatism, and "bust developers," not to mention cancer "cures."

A mental health program of study in nine fields has been set up. Inspecting this country's 79 medical schools and about 1,300 hospitals approved for training interns and residents requires the full time of nine A.M.A. physicians. The aggressive program of aid to medical education is well known.

Activities of the Public Relations Department are legion and reach to all levels of medicine's relations with the public. Last year's expenditure of $385,000 here was greater than for any of the other departments, bureaus, councils or committees. The Council on Medical Service steadily pursues its broad aim, "to study the effect of social and economic change on the practice of medicine and to report these changes to the profession." One of its seven important committees covers voluntary health insurance, emphasizing at present catastrophic coverage and eliminating abuses of health insurance. The Bureau of Medical Economic Research reports at times some startling results from its study of the supply, demand, cost and prices of medical care. Legislation also shares in the host of activities outside the scientific and journalistic fields.

The visitor finds that behind the scenes at A.M.A. headquarters the countless activities are aimed at the protection and promotion of the health of the American people. Here is no "cold, impersonal giant brooding over the medical world," but a tremendous going concern, accomplishing a worthy task in heartwarming fashion. Without it, where would the profession and the nation turn for the essential services it renders? The next time you are up Chicago way, Doctor, by all means take the tour and see for yourself how rich you are to have a stake in this invaluable enterprise.

Cooperation in Consultation

Medical consultation has a technic all its own, which, when properly carried out, offers the strongest kind of proof to the public that physicians are capable of managing their own affairs. Good cooperation in consultation has made much progress, but can stand considerably more bolstering. Strengthening relationships in this phase of medicine advances the cause of medicine; as a medical group and singly, general practitioners and specialists alike stand to benefit by the proper exchange of services, and, most of all, the patient benefits.

The general practitioner is widely and variously acclaimed as the backbone, the cornerstone and the bulwark of American medicine. In some areas he is the sole guardian of health, covering broad expanses of territory that appall his urban counterpart. Equally staggering are the number of patients he sees and the variety of diseases he treats in the thickly populated areas. No one would minimize his importance nor his ability and versatility in his many varying roles. Nevertheless, the physician of integrity readily admits that one physician cannot know all there is to know about every medical subject.

On the other hand, the specialist, entitled as is the general practitioner to choose the field of medicine he prefers, seeks to know as much as possible about some one branch of medicine that has special appeal. Some popular magazine articles to the contrary notwithstanding, the idea

of specialization is anything but new. It is, in fact, as ancient as the Hippocratic oath, and evidence of consultation dates as far back as medicine itself. There are today about 20,000 certified specialists among some 200,000 practicing physicians in this country,[1] a number sufficient to make them available in many more smaller communities than ever before. More and more frequently, practitioners are seeking advice along special lines, not because they are less able, but because such assistance is more readily available. Too, an educated laity nowadays appreciates that there is a natural limit to ability and that two heads are better than one, especially in such a vast field as medicine. When the relationship between the general practitioner and the specialist is good, the community benefits because its needs are best served. An atmosphere of competition and rivalry, however, may cause the family physician to hesitate to seek the services of a colleague on a difficult case.

When a consultation is advisable, and it not infrequently is for any one of many valid reasons, it should be the prerogative of the family doctor to call in the best qualified specialist in the community. He is in a much better position than the patient or family to know who is recognized in medical circles as having the ability best to meet the situation to be confronted. He then should have ready for the specialist all available information including roentgen studies and laboratory data, unless extreme emergency prevents.

Many thoughts may arise to plague the attending physician when he calls for help, but the question of the consultant's conduct is likely to give him the greatest concern. His anxieties need have no foundation, however, in the opinion of Graham,[1] if the two review in advance a few simple and logical rules of procedure, thereby avoiding conflict or misunderstanding and giving advisory practice "the boost it needs to play its role in better medicine."

If there is any question regarding fees, they should be agreed upon before the visit is made. The range of fees for various services is usually well known to a referring physician with a little experience. Under unusual circumstances, a few direct words should straighten the matter out and avoid surprises for any concerned.

The role of the consultant is primarily to remain in character, so to speak, and not to take the center of the stage. He is there to render his services through the attending physician, and the ideal consultant will go out of his way to keep the physician in charge very much in the picture. In a warm and friendly manner, he will even make it clear to those concerned that he intends to leave the patient in the capable hands of his colleague. If he is in accord with the procedures already employed, he should say so and avoid the temptation to make minor changes. He should of course be given every opportunity to evaluate the case thoroughly under the best possible circumstances, and is entitled to a completely cooperative attitude on the part of the family physician.

It is preferable that they see the patient together, but discuss the case elsewhere in private. Should the consultant disagree, wholly or in part, with the routine being followed, it is his obligation to discuss his differences with the referring physician before anything is said to the patient or family. Then he is in a position to say that he and the attending physician have agreed on a new program. When he has rendered his opinion, he should withdraw from the case, indicating by a friendly word that his work is done and the case completely in the hands of the family physician unless further developments make his reappearance desirable.

In the interweaving of the medical services, the general practitioner and the specialist find it mutually advantageous to work as a team, pooling their ideas for the welfare of the patient as medical needs dictate. Deportment in consultation characterized by dignity and propriety promotes an active exchange of services for the solution of certain clinical problems. The satisfactory outcome in innumerable instances serves to strengthen the relationship between the laity and the medical profession and to advance the cause of medicine immeasurably.

1. Graham, H. K.: Relationships in Consultation, California Med. 79:240-243 (Sept.) 1953.

1954 MEDICAL DISTRICT MEETINGS

"A" Marianna	October 11
"B" Sanford	October 13
"C" Sarasota	October 15
"D" Vero Beach	October 14

Eighty-Third Congress and Medical Legislation

Now that the Eighty-Third Congress has become history, one of its accomplishments was the passing of more health and medical legislation than any Congress in many years. The President's signature is hardly dry on the supplemental appropriation bill at this writing, but as soon as he signed it on August 26, Hill-Burton hospital construction officials in the Department of Health, Education, and Welfare began making allotments to the states under the newly expanded program. Discussions were begun at once with state Hill-Burton agencies on regulations required by the Congress to carry out the program. Available to the states this year will be federal grants of six and a half million dollars for hospitals for the chronically ill, a like amount for diagnostic-treatment centers, four million for rehabilitation centers, and also a like amount for nursing homes. Grants will be made on the basis of per capita income and population, as with the regular Hill-Burton allotments. In addition, each state is scheduled to get a minimum of $25,000 for surveys of future needs; states must match this money.

Latest statistics from the Division of Hospital Facilities, Public Health Service, show that 2,283 Hill-Burton projects have been approved under the program at a total cost of $1,849,207,000, with the federal contribution $617,653,000. Florida benefits under the Hill-Burton Act were reviewed editorially in the September Journal.

The law transferring supervision of hospitals of the Indian Bureau, which is under the Interior Department, to the Public Health Service, which is under the Department of Health, Education, and Welfare, gives promise of alleviating poor health conditions in Indian areas. Many of these areas, declared Commissioner of Indian Affairs Glenn L. Emmons, have been "practically untouched by the great advances in public health protection which have taken place throughout the country during recent decades." For several months the Bureau has been building up the staff of professional sanitarians, health educators and other health specialists in preparation for the changeover, effective next July 1. The Indian bill has the endorsement of the American Medical Association.

A more dynamic vocational rehabilitation program went into effect with enactment of a law authorizing gradual increases in federal appropriations, but at the same time aimed at bringing the states up to the position of full financial partners by the end of five years. The goal is to rehabilitate at least 200,000 persons annually in place of the present 60,000, thus rehabilitating a greater number and inducing the states to participate more actively in the work.

The new tax revision law provides more liberal tax deductions for families with unusually large medical expenses. They may now deduct medical expenses in excess of 3 per cent of taxable income. Under the old law the figure was 5 per cent. A family with a $3,000 income and $150 in medical expenses under the old law could deduct nothing, but under the new law $60. The Treasury estimates a saving to families of eighty million dollars.

One of the final acts of the Congress was passage of the administration's social security expansion bill, bringing some 10 million additional persons under social security on next January 1. Excluded are physicians, dentists, osteopaths, chiropractors, veterinarians, naturopaths and optometrists.

The health reinsurance bill, the one bill that was defeated, was perhaps the most publicized. Editorial comment in The Journal last month explained the opposition of the American Medical Association to it, which was shared by most health insurance companies, the United States Chamber of Commerce and several other professional groups. The defeat was a disappointment to the President, who stated, "Health reinsurance we are going to put before the Congress again because we must have a means open to every American family so that they can insure themselves cheaply against the possibility of catastrophe in the medical line." To reporters Secretary Oveta Culp Hobby of the Department of Health, Education, and Welfare commented, "We cannot complain about what happened in legislation. . . . The only setback was health reinsurance being recommitted. It was a new and novel idea and many new and novel ideas do not get by the first time." She expressed the hope that a better and more specific bill could be written in the next Congress.

The Eighty-Fourth Congress convenes on January 5, 1955. The day after promising anew in a nationwide radio-television address to press for his reinsurance plan in the next Congress, the President also stressed the need for increased medical

care for military dependents. Said he: "These patriotic men and women, whose morale, skill, and dedication to service are so important to us all, now lack adequate medical care for dependents and reasonable survivorship benefits for their families. It is most important that these needs of armed forces personnel, serving their country often in remote corners of the world, engage our serious consideration."

Southern Medical Association St. Louis Meeting Nov. 8-11, 1954

The Forty-Eighth Annual Meeting of the Southern Medical Association will be held early next month in St. Louis, where it has met four times previously. Opening on Monday, November 8, it will continue through Thursday, November 11. The plan of the meeting corresponds to that carried out for the last three years. There will be the opening assembly on Monday morning, to which the public will be invited. Forty-eight half day sessions will be held, beginning on Monday afternoon and continuing to Thursday noon. Social features will include the Doctor's Day luncheon on Tuesday, sponsored by the Woman's Auxiliary, and the association dinner on Wednesday night.

St. Louis has excellent facilities for handling the meeting. Its beautiful Kiel Municipal Auditorium, headquarters for the meeting, is familiar to many members. The exhibit space and the rooms for the meetings are unsurpassed. Also familiar are the many attractions of St. Louis, for the association met there as recently as 1950, and also in 1944, 1941 and 1935.

The comprehensive program has been planned to interest all physicians, whatever their specialty. The many sectional programs provide complete coverage of the year's progress and permit the doctor to broaden his viewpoint in any direction he chooses. A number of Florida physicians are participating in the program.

The officers of the association, the staff, and the St. Louis physicians are making every effort to have a most successful meeting and to insure for all who attend a profitable and enjoyable time. Florida doubtless will be well represented.

National Nurse Week October 11-16

National Nurse Week will be observed throughout the nation this month by official decree of the Congress. The week of October 11-16 has been designated for this purpose. To help coordinate activities in connection with its observance, a committee with representatives from sponsoring organizations was formed on August 25, at the call of Representative Frances Bolton (R., Ohio), author of the joint resolution that established the annual observance. President Eisenhower signed the resolution on August 23. The cooperating groups planning for the week include the American Medical Association, American Nurses Association, National League for Nursing, American Hospital Association, and the Department of Defense, Department of Health, Education, and Welfare, and Veterans Administration.

"National Nurse Week," Mrs. Bolton declared, "is designed to shift public information emphasis in nursing from the shortage of nurses to the positive services provided by nursing personnel."

Invitation to Jamaica Meeting of British Medical Association December 3-4, 1954

The British Medical Association, Jamaica Branch, has extended an invitation to President Duncan T. McEwan personally and also to the officers and members of the Florida Medical Association to attend its Annual Conference, which is being held in Kingston, Jamaica, on Friday and Saturday, December 3 and 4, 1954. The Conference has been planned to follow immediately after the Clinical Session of the American Medical Association, which will convene in Miami on November 29 and continue through December 2.

The Jamaica physicians have invited the president, officers and members of the American Medical Association to this postconvention official meeting with them and have chosen the time for their Conference accordingly. Arrangements are being made to hold a special session on Saturday morning, December 4, with representatives of the American Medical Association participating in the program. In the evening a reception and dance will be held, at which the guests will be specially received by His Excellency the Governor of Jamaica.

The Jamaica branch of the British Medical Association is the oldest branch of that organization. Its secretary, Dr. J. T. Burrowes, in extending the invitation, related that it was founded in 1877 and now represents over 300 doctors in Jamaica. They will be happy to welcome physicians from Florida and throughout the nation to their beautiful island for their meeting and for vacation pleasures.

Graduate Medical Education Hematology Seminar November 18-20

The Hematology Seminar will be held at the George Washington Hotel in Jacksonville, beginning on Thursday, November 18, and continuing through Saturday, November 20. Dr. William Dameshek, Director, Blood Research Laboratory, New England Center Hospital, Boston, and his associate Dr. J. Komninos, Blood Research Laboratory, New England Center Hospital, Boston, will be the distinguished out-of-state lecturers. Dr. James N. Patterson, member, American Board of Pathology, Tampa, and Dr. John B. Ross, Director, Jacksonville Blood Bank, Jacksonville, are the Florida speakers. This course, which affords physicians and technicians an exceptional opportunity for special training, will be presented by the Department of Medicine of the Graduate School of the University of Florida, in cooperation with the Florida Medical Association and the Florida State Board of Health.

Advance registration is requested, as designated on the programs, which will be mailed to all physicians of the state. The registration fee is $25 for physicians and $15 for technicians.

The program is as follows:

PROGRAM
HEMATOLOGY SEMINAR

THURSDAY, NOVEMBER 18

I. Anemia: General practices, classifications, et cetera
Dr. Dameshek

II. Deficiency Anemias: Including pernicious anemia and iron deficiency
Dr. Patterson

III. Hemolytic Anemia: General principles
Dr. Dameshek

IV. Hemolytic Anemia: Special tests
Dr. Komninos

V. Disorders of Abnormal Hemoglobin
Dr. Ross Discussion, Dr. Dameshek

FRIDAY, NOVEMBER 19

VI. Hemostatic Disorders: General outline, principles of coagulation
Dr. Dameshek

VII. Hemophilia and Associated States
Dr. Patterson

VIII. Thrombocytopenia
Dr. Dameshek

IX. Transfusions Including Platelet Transfusions
Dr. Komninos

X. Hypersplenism
Dr. Dameshek

XI. Motion pictures: Two films on hemolytic anemia, one on hemostasis

SATURDAY, NOVEMBER 20

XII. Leukemia and Leukosarcoma: General principles and classification
Dr. Dameshek

XIII. Chemotherapy of Leukemia and Associated States: Panel discussion
Drs. Dameshek, Komninos and Patterson

XIV. Slides and Motion Pictures of Cells

The program for the Diabetes Seminar on October 21 and 22, 1954 was published in the August Journal. The Seminar is to be a feature of the second annual meeting of the Florida Clinical Diabetes Association, to be held at the San Juan Hotel in Orlando. The guest lecturers are Dr. H. B. Mulholland, University of Virginia School of Medicine, Charlottesville, Va., and Dr. Joseph T. Beardwood Jr., Philadelphia.

American Medical

Association

Clinical Session

Miami

Nov. 29 - Dec. 2, 1954

Florida Pediatric Society St. Petersburg, Oct. 22-24

The Florida Pediatric Society will hold its twenty-first meeting on October 22, 23 and 24, at the Tides Hotel at Redington Beach near St. Petersburg. This 1954 fall meeting will convene at 2 p.m. on Friday and continue through Sunday noon.

Three distinguished guest speakers will present the scientific program. The first speaker at the opening session will be Dr. Robert B. Greenblatt, Professor of Endocrinology, Medical College of Georgia, Augusta, Ga. He will be followed by Dr. William S. Langford, Professor of Psychiatry, College of Physicians and Surgeons, Columbia University, New York City. Both will deliver lectures on Saturday also. Judge Leo Blessing, Orleans Parish Juvenile Court, New Orleans, and Secretary, National Conference of Juvenile Court Judges, will address the society twice on Saturday. The annual business meeting will follow a panel discussion on Sunday morning. Several of the lectures will be of interest to the wives and husbands who are accompanying the members of the society. A cordial invitation is extended to them to attend.

There will be several social events for all to enjoy. The first social gathering is scheduled for the cocktail hour on Friday evening. On Saturday morning there will be a special breakfast. Following the 5:30 cocktail hour on Saturday evening there will be a buffet supper.

The scientific program follows:

PROGRAM

TWENTY-FIRST MEETING

FLORIDA PEDIATRIC SOCIETY

TIDES HOTEL, REDINGTON BEACH

ST. PETERSBURG

FRIDAY, OCTOBER 22

2:00- 3:00	"Disorders of Menstruation in the Adolescent Girl"	Dr. Greenblatt
3:15- 4:15	"Psychological Problems of the Adolescent Associated with the Drive for Emancipation and Independence"	Dr. Langford

SATURDAY, OCTOBER 23

9:30-10:30	"Adolescent Problems in the Family of Today"	Judge Blessing
10:45-11:45	"Developmental Disorders"	Dr. Greenblatt
	1. "Disorders in Growth"	
	2. "Precocious Puberty"	
	3. "The Problem of the Pseudohermaphrodite"	
2:00- 3:00	"Psychological Problems of the Adolescent Associated with Sexual Maturation"	Dr. Langford
3:15- 4:15	"Adolescent Problems in the Family of Today" (continued)	Judge Blessing

SUNDAY, OCTOBER 24

9:00	Panel Discussion. Questions and Answers.	
	Annual Business Meeting	

World Medical Association Appeals for New Members

Physicians throughout the country who are affiliated with the World Medical Association have recently received letters urging immediate support to relieve the present financial plight of this only independent international organization bearing the torch of free enterprise for the doctors of the world. The decrease in support from industry as a whole is one reason for the depleted treasury. In addition, the campaign to increase individual membership in the United States Committee has not been as successful as expected. Funds on hand are not sufficient either to handle the General Assembly or run the association for another year.

Accordingly, Dr. Louis H. Bauer, the secretary-treasurer of the United States Committee, has made an urgent appeal to members to talk about the World Medical Association to their friends and sign them up for membership. The membership fee is only $10.

Since its founding in 1947, the World Medical Association has earned increased respect from international governmental organizations. "But," says Dr. Bauer, "there is a constantly growing tendency for decisions affecting all of medicine to be made at the international level. This tendency is a threat not only to the future of medicine itself, but to the rights and privileges of every practicing physician. One example is the current attempt of incompetent organizations to draft a Code of International Medical Law which would affect all physicians in peace as well as in war. The World Medical Association is the only international organization which can and does speak from the nongovernmental standpoint and from the standpoint of free enterprise. However, it can only continue to defend your interests if it has adequate financial support."

Dr. Bauer is therefore asking physicians all over the nation to join in a renewed membership campaign. Application blanks may be obtained from Dr. Louis H. Bauer, World Medical Association, 345 East 46th St., New York 17, N. Y.

Radiological Society Consultation Service

President A. Judson Graves of the Florida Radiological Society has announced the formation of a committee "to offer experienced consultation service on any matter concerning radiology and its relationship to hospital service, or its relation to other practicing physicians." The members of the committee are: Drs. John J. McGuire, Pensacola, Thomas H. Lipscomb, Jacksonville, Nelson T. Pearson, Miami, and Gerard Raap, Miami. Dr. Raap is secretary of the committee and also Councilor for the American College of Radiology. This service is offered in the interest of better understanding between hospital executives and staffs and member radiologists, to the end that more efficient service may be available to the patient. The committee was formed in line with the recommendation of the American College of Radiology, the American Hospital Association and the American Medical Association and was approved at the April meeting of the society.

The duties of the committee consist of receiving complaints from any source, investigating their merits and attempting to reconcile differences. The committee will maintain close liaison with local radiologic societies, county medical societies and the Florida Medical Association. Problems may be submitted to any member of the committee in the respective districts or to James T. Shelden, M.D., Secretary of the Florida Radiological Society, P. O. Box 1021, Lakeland.

1954 MEDICAL DISTRICT MEETINGS

"A" Marianna	October 11
"B" Sanford	October 13
"C" Sarasota	October 15
"D" Vero Beach	October 14

OTHERS ARE SAYING

Tags for Special Problems

For a number of years, the idea has been promulgated that diabetics should carry an identification card that includes the information that they have diabetes. This has served a valuable purpose for prompt recognition of hypoglycemia. Less often, but no less important, it has made a significant difference in the diagnostic and therapeutic approach to the problem of a diabetic patient who has been severely injured or who has had something like cerebral apoplexy and is temporarily unable to tell the doctor about his diabetes. This second advantage has been extended to other categories of disease — epilepsy, Ménière's syndrome, and drug idiosyncrasy. For this last, an identification card has been especially recommended for people who have had severe reactions to horse serum or penicillin and in whom there is thought to be serious threat of anaphylactic shock from another administration.

Although the idea of identification of people who require special handling in these various ways is well founded, it is hard to avoid the worry that identification cards are easily lost or overlooked in an emergency. This worry would be all the greater in a time of mass disaster when the physician faces the problem not of an individual patient but of a multitude of sick or injured. It might be argued that the number of people, under disaster conditions, who require special consideration of this sort, would be a small percentage of the total. Still, it seems a shameful waste that a patient who has lived through a fire or a tornado or a bombing should run a double jeopardy because he cannot tolerate penicillin or tetanus antitoxin that might be given.

Perhaps this is a field of "preventive medicine" in which civil defense agencies might take a special interest. In many communities, metal identification tags have been issued to all citizens. It would be simple enough to devise a set of symbols for use on these tags for indication of the kind of special information being discussed. Of course, not many citizens bother to wear their identification tags, but diabetics and reactors to drugs might do so because of the advantages peculiar to them. It might be even better to affix the symbol to the patient by means of a small tatoo in some inconspicuous place like a buttock. If this is too reminiscent of Dachau and Buchenwald, at least it is scientifically preferable and seems a small price for protection.

—GP, June 1954

The Importance of the Deferred Diagnosis

The two paramount questions in a patient's mind when he consults his physician are: What is wrong with me? What has to be done to make me well again?

All the rules of logic indicate that the answer to the second question is impossible without the proper answer to the first.

How often do we fly in the face of this logic and fire therapeutic salvos before the targets are located?

In probing the reasons for these all too frequent trigger happy situations we must examine some aberrations of the patient-physician relationship. Many a patient with a dominant personality and ignorant of the sound rudiments of medical practice will put strong pressure on his medical advisor to come up with a quick, and usually inaccurate, diagnostic guess before adequate evidence is available. The physician who fails to resist such pressure and is stampeded into premature action does disservice to his patients and proves that he is afraid to deny that he is omniscient.

Why should a conscientious physician after careful study of an occasional rare obscure case that defies diagnosis be ashamed to classify it as "diagnosis deferred"?

Our social and professional obligations as physicians include a grass roots type of patient education in the how and the why of modern medical diagnosis.

—Westchester (New York) Medical Bulletin, July 1954

Our Commandments

1. The patient is the most important person in the hospital.

2. The patient is dependent on us; our reputation is dependent on him.

3. The patient is not an interruption of our work — he is our work.

4. The patient does us a favor when he calls; we are not doing him a favor by serving him.

5. The patient is not someone to argue with — but someone to comfort.

6. The patient is a part of our business — not an outsider.

7. The patient is not a cold statistic; he is flesh and blood human being with feelings and emotions like our own.

8. The patient is a person who brings us his illness — it is our duty to justify his faith in us.

9. A patient is deserving of the most courteous and attentive treatment we can give him.

10. Remember always, if people did not become ill, there would be no need for this or any other hospital.

(Courtesy Georgia Hospital Association)

The above-borrowed summary merits the consideration of all hospital personnel. The spirit of love and service indeed should charge the atmosphere of every hospital. The patient shall never be a number; he must be an individual known by his name. If the patient is properly served, the books will balance themselves. Specific drugs for specific diseases are very important, but the heart and the soul oftentimes need understanding attention. The hospital can do much to cure the ill patient, but it can further help to return him home a grateful, strengthened, and a more useful citizen.

—*The Mississippi Doctor, July 1954*

Medical Officers Returned

Dr. Clyde F. B. Smith, who entered military service on Aug. 1, 1952, was released from active duty on July 22, 1954 with the rank of captain, medical corps, U. S. Army. His address is 9520 Harding Avenue, Miami Beach.

BIRTHS AND DEATHS

Births

Dr. and Mrs. Leo A. Zuckerman of Miami announce the birth of a son, Ivan Niles, on July 20, 1954.

Dr. and Mrs. Frank L. Fort of Jacksonville announce the birth of a daughter, Phyllis Lee, on Aug. 3, 1954.

Dr. and Mrs. J. Q. U. Thompson of Jacksonville announce the birth of a daughter, Patricia Ann, on Aug. 10, 1954.

Dr. and Mrs. Charles F. McCrory of Jacksonville announce the birth of a son, Paul Leslie, on Aug. 23, 1954.

Dr. and Mrs. Thomas W. Meldrum of Jacksonville announce the birth of a son, William Buell, on Aug. 28, 1954.

Dr. and Mrs. Rothwell C. Polk of Jacksonville announce the birth of a son, Richard Lee, on Aug. 30, 1954.

Deaths — Members

Stokes, Thos. H., Pensacola	Aug. 8, 1954
Palmer, Bascom H., Miami	Sept. 2, 1954
Martin, Paul H., Jacksonville	Sept. 3, 1954

Deaths — Other Doctors

West, John R. III, New York	June 29, 1954
Dunn, Joseph C., Cooperstown, Pa.	Aug. 9, 1954

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Baker, Wilmoth H. (Col.), Tallahassee

Biggane, Charles F. Jr., North Miami

Burley, Dwight B. Jr., Miami

Coleman, Benjamin, Miami

Galluccio, Anthony C., Hollywood

Ingram, William Jr., Jacksonville

Langley, Thomas E., Eustis

Lehmann, Albert, Pensacola

Lincoln, John L., Tallahassee

Meadows, Burton T., Coral Gables

Moss, Herman, Jacksonville

Packard, John M., Pensacola

Ryle, Winfred E., Pensacola

Simon, Herbert J., Hollywood

Smith, Edward R., Jacksonville

Tight, Alvin J., Fort Lauderdale

Weinkle, William S., Miami Beach

STATE NEWS ITEMS

The Florida Academy of General Practice will hold its fifth annual Scientific Assembly this month at the San Juan Hotel in Orlando. Beginning at 11 a.m. on Sunday, October 17, the meeting will continue through Monday, October 18. The excellent program, which was published in the September Journal, should insure a record attendance, attracting both general practitioners in large numbers and specialists in the various fields of medicine, for the meeting is open to nonmembers. There is no registration fee.

The special guest speaker is Dr. John Eric Peterson of Los Angeles. He is Senior Attending Physician and Chief of Medical Service at White Memorial Hospital, Senior Attending Physician at the Los Angeles County Hospital, and Clinical Professor and Head of the Department of Medicine at the College of Medical Evangelists School of Medicine. In addition, the 14 other lecturers on the program include the Deans of Florida's two medical schools and eminent speakers both from without and within the state.

The concluding feature of the Scientific Assembly will be a clinicopathologic conference on Monday afternoon. There will follow a social hour and a banquet at 8 p.m.

On Dec. 2, 1954, immediately following the Clinical Session of the American Medical Association, the seventh annual Southeastern States Cancer Seminar will convene at the McAllister Hotel in Miami and will continue through December 4. The speakers and their subjects were published in the September Journal. The program is outstanding, and the twelve lecturers are eminent authorities from over the nation, each particularly fitted to present the subject assigned.

Dr. Ashbel C. Williams of Jacksonville attended a meeting of the third region of the American Cancer Society in Nashville in June.

Drs. Sullivan G. Bedell and Richard G. Skinner Jr. of Jacksonville attended a meeting of the Board of Directors of the Florida Association for Mental Health in Daytona Beach in June.

President Duncan T. McEwan of Orlando was guest speaker at the luncheon held in conjunction with the Midyear Board Meeting and Conference of County Presidents and Presidents-elect of the Woman's Auxiliary held at the Tides Hotel on September 22.

Dr. McEwan introduced the guest speaker, Dr. Stewart H. Clifford of Brookline, Mass., at the opening session of the Tri-State Obstetric-Pediatric Seminar on September 13 in Daytona Beach.

Dr. Sidney Grau of St. Petersburg spoke on "Facts and Fallacies of Heart Disease" at the Shrine Club Luncheon in that city on July 26.

Dr. Kenneth M. Davis of Delray Beach was cited by the city council in resolution on July 27. The document pointed out that Dr. Davis had served the city as health officer without remuneration for many years.

Dr. Alvin E. Murphy of Palm Beach will be director of the Cardiac Clinic of Palm Beach County sponsored by the Heart Association. Acting as assistant directors are Drs. Sidney Davidson, Lake Worth; Oscar L. Kelley, Palm Beach; and Ralph M. Overstreet Jr. and Saul D. Rotter, both of West Palm Beach.

Dr. Rothwell C. Polk of Jacksonville spoke on "Cancer of the Breast" before the Woman's Auxiliary, Post No. 88, the American Legion, in Jacksonville on August 17.

Dr. Irwin S. Leinbach of St. Petersburg spoke on "Optimism in Europe in 1954" at a meeting of the International Club on August 19. On August 26 he spoke at a luncheon meeting of the Exchange Club of St. Petersburg on "My Observations in Europe in 1954."

Dr. J. Maxey Dell Sr. of Gainesville was appointed recently by acting governor Charley E. Johns to the Florida Improvement Commission.

Drs. George C. Hopkins and Richard J. Langston of St. Augustine spoke on polio at a meeting of the Business and Professional Woman's Club of that city on August 19.

Dr. Hugh A. Carithers of Jacksonville gave several lectures at the Southern Pediatric Seminar at Saluda, N. C., in July.

Dr. Jere W. Annis of Lakeland attended the World Congress of Cardiology in Washington, D. C., September 12-18. Also in attendance was Dr. Ashton Graybiel of Pensacola, captain, MC, USN, United States Naval School of Aviation Medicine, who is president of the American College of Cardiology.

Dr. James N. Patterson of Tampa and Dr. Sherman R. Kaplan of Miami Beach took part in the Medical Technology Workshops sponsored by the General Extension Division of the University of Florida. Dr. Patterson taught the course in hematology in Gainesville, August 27-29, and Dr. Kaplan taught the hematology course at Barry College, Miami Shores, September 10-12.

Dr. Russell B. Carson of Fort Lauderdale will discuss a paper at the meeting of the South Central Section, American Urological Association in Colorado Springs, October 18-20. Dr. Carson is an honorary member of this association and a past president of the Southeastern Section of the American Urological Association.

Dr. George Gittelson of Miami has returned to his practice following a month's training in allergy at the Cook County Graduate School of Medicine in Chicago.

Drs. Lee E. Bransford Jr., Hugh A. Carithers, John F. Lovejoy, Edward R. Smith, G. Dekle Taylor and Gary E. Turner of Jacksonville took part in a program on "Community Sources Relating to Chief Health and Development" as part of the Exceptional Child Education Program in August.

Drs. Turner Z. Cason and Clarence M. Sharp of Jacksonville have been appointed to a state committee to explore the possibilities of widening mass X-ray surveys to include a better cancer finding program.

Dr. George R. Crisler of Winter Park discussed a film entitled, "Retire to Life," at a recent monthly meeting of the Pilot Club of Orlando.

Dr. George D. Hopkins II of Fort Myers spoke on his experiences as a physician in the Korean War at a meeting of the Kiwanis Club of that city on August 4.

Dr. Isabel Roberts of Melbourne spoke on cancer research and treatment at a meeting of the local group of Missile Misses on July 30.

Dr. Gretchen V. Squires of Pensacola spoke on the medical examiners system at a meeting of the Pensacola Kiwanis Club on August 4.

Dr. Robert J. Needles of St. Petersburg spoke at the meeting of the American Medical Association in San Francisco in June, and a report on his talk was carried on page one of the San Francisco Chronicle. The subject of his talk was the fact that doctors have failed to cure the most common disease — unhappiness.

Dr. Joseph L. Rubel of Pensacola spoke on "Various Types of Mental Retardation in Children" before the Escambia County Association for Help to Retarded Children on August 11.

Dr. Frank J. Pyle of Orlando has been appointed to head the doctors' division of the October Red Feather campaign of United Community Services.

Dr. Cecil E. Miller of Sarasota, head of the medical unit of the Sarasota County Defense Program, has asked Dr. William L. Wright and Dr. Henry J. Vomacka to set up a plan for the doctors to organize and to establish a medical disaster plan in cooperation with the civil defense program.

Dr. Maurice Lev of Miami Beach, director of the research laboratories at Mount Sinai Hospital, has received a grant of $5,000 from the American Heart Association. The money is specified for a study of the conduction system in congenitally abnormal hearts.

Drs. John W. Williams and William A. Hodges Jr. of Lakeland participated in a symposium on acute leukemia at a recent meeting of the staff of Morrell Memorial Hospital.

The Ninth Annual University of Florida Midwinter Seminar in Ophthalmology and Otolaryngology will be held at the Sans Souci Hotel in Miami Beach the week of Jan. 17, 1955. The lectures on Ophthalmology will be presented on January 17, 18, and 19, and those on Otolaryngology on January 20, 21, and 22.

Dr. I. Leo Fishbein of Miami Beach recently attended the meetings of the International Institute of Child Psychiatry, the First International Congress of Group Psychotherapy and the Fifth International Congress on Mental Health, in Toronto, Canada.

Dr. Floyd L. Pichler of Jacksonville entered the United States Public Health Service on August 16 with the rank of lieutenant.

Dr. Robert V. Artola of West Palm Beach attended the Obstetric Session of the Southern Pediatric Seminar at Saluda, N. C., July 25-31.

Dr. Thomas C. Black of Alexandria, La. gave a paper on "Coexistent Tuberculosis and Fungus Disease" at the annual meeting of the American Academy of Tuberculosis Physicians on June 19 in San Francisco.

Dr. William C. Fontaine of Panama City has been named as director of the Bay County Cancer Clinic which is expected to be opened soon.

Dr. Wade S. Rizk of Jacksonville spoke on "The Historical Development of X-ray and its Contribution to Medicine," before the Beaches Rotary Club on July 30.

Dr. Webster Merritt of Jacksonville recently spoke before the Chattahoochee Valley Historical Society.

Dr. Lawrence R. Medoff of Miami attended the International Conference on Thrombosis and Embolism at Basel, Switzerland in July 1954.

Dr. Meredith F. Campbell of Miami has been appointed as Emeritus Professor of Urology, New York University, where he taught urology in the School of Medicine for thirty years. He was also appointed consultant to Bellevue Hospital in New York City.

SAINT LOUIS Welcomes You!

48th ANNUAL MEETING
SOUTHERN MEDICAL ASSOCIATION
November 8, 9, 10, 11

A Complete General Medical Meeting

- OPENING ASSEMBLY
- SECTION SESSIONS

Presented by the following sections of the Association: Medicine, Surgery, Ophthalmology and Otolaryngology, Public Health, Industrial Medicine and Surgery, Medical Education and Hospital Training, Gastroenterology, Urology, Obstetrics, Gynecology, Orthopedic and Traumatic Surgery, Neurology and Psychiatry, Dermatology and Syphilology, Pediatrics, Radiology, Pathology, Allergy, Proctology, Anesthesiology, General Practice, Physical Medicine and Rehabilitation.

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- MEDICAL MOTION PICTURES
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- NO REGISTRATION FEE

Hotel Accommodations are Available and may be secured by writing:
HOUSING BUREAU,
Southern Medical Association,
911 Locust Street, Room 406, St. Louis 1, Missouri.

SOUTHERN MEDICAL ASSOCIATION
Empire Building
BIRMINGHAM, ALABAMA

SEE YOU IN MIAMI . .

Eighth A.M.A. Clinical Session

November 29-December 2, 1954

HOTELS AND RATES

Hotel	Single	Double or Twin
Alcazar	$ 5.00- 6.00	$ 6.00- 9.00
Alhambra		8.00
Belfort	5.00	6.00- 7.00
Berni	4.00- 5.00	4.00- 7.50
Biscayne Terrace	10.00	12.00-16.00
Columbus—Headquarters Hotel (No rooms available)		
Cortez	4.00	6.00
Dallas Park		
El Comodoro	5.00-10.00	10.00
Everglades	6.00- 8.00	8.00-12.00
Leamington		6.00
Liberty		6.00
McAllister—Headquarters Hotel (No rooms available)		
Miami Colonial	5.00- 6.00	8.00-10.00
Miramar	4.00	6.00- 9.00
Paramount		8.00-10.00
Patricia	5.00	8.00
Plaza	5.00	7.00- 8.00
Ponce de Leon	8.00	10.00-12.00
Robert Clay	7.00	8.00-10.00
Towers		7.00- 8.00
Towne Motel		8.00
Tuttle		6.00

A number of excellent motels are located on Brickell Street and South Bay Shore Drive.

If you wish accommodations at a Miami Beach hotel or motels, make direct reservations rather than through the A. M. A. (Miami) Housing Bureau.
All reservations for hotels listed must be cleared through the Housing Bureau and must be received before November 1, 1954. Make your hotel reservations now!
Use the form below and mark your calendar so that you'll be in Miami November 29 through December 2, 1954.

Make your hotel reservation now!

APPLICATION FOR HOTEL ACCOMMODATIONS

Dr. Hunter B. Rogers, Chairman
Subcommittee on Hotels
320 N.E. Fifth Street, Miami, Florida

Please make reservations noted below:

Hotel ..... (First Choice) Hotel ..... (Second Choice)

Hotel ..... (Third Choice)

..... Single Room(s) @ $ .... Twin Bedroom (s) @ $ .....

..... Double Bedroom(s) @ $ .... Parlor, Bedroom Suite @ $ .....

Arrival: ....., at ..... a.m. ..... p.m. Departure: ....., at ..... a.m. ..... p.m.

Names of all occupants: **Addresses:**

(Please attach list of additional names if you do not have sufficient space here.) If you are a Technical Exhibitor, be sure to give name of firm and individuals to occupy room or rooms reserved.

Check for $ ..... payable to A. M. A. Housing Bureau is enclosed to bind this reservation.

Mail confirmation to: Signature .....

Address .....

Please enclose a stamped, self-addressed envelope

COMPONENT SOCIETY NOTES

Dade

At the regular meeting of the Dade County Medical Association on September 7, Dr. Clifford C. Snyder spoke on "Recent Advances in the Transplantation of Skin."

DeSoto-Hardee-Highlands-Glades

The DeSoto-Hardee-Highlands-Glades County Medical Society has paid 100 per cent of its state dues for 1954.

Escambia

The Escambia County Medical Society has paid 100 per cent of its state dues for 1954.

Jackson-Calhoun

The Jackson-Calhoun County Medical Society has paid 100 per cent of its state dues for 1954.

Lake

The Lake County Medical Society held regular monthly meetings at the Grandview Hotel in Eustis on August 4 and September 1.

The Society voted unanimously to furnish a physician at each of the home football games this season. Thirty-five games will be played in the county this fall. The society will attempt to get the assurance of a like coverage when their home teams play in other counties.

Palm Beach

The Palm Beach County Medical Society, with the cooperation of the County Health Department and The Palm Beach Post-Times, will present free medical forums again this year. The five forums will be held on Tuesday evenings, October 19 through November 16, in the Palm Beach High School Auditorium. Dr. Oscar L. Kelley of Palm Beach is chairman of the forum committee, and its members are Drs. C. Jennings Derrick, Burton F. Barney and Younger A. Staton of West Palm Beach and Bailey B. Sory Jr. of Palm Beach.

Pinellas

At the regular meeting of the Pinellas County Medical Society on September 13, Mr. Frank Castor, Director of the State Narcotic Bureau, Jacksonville, spoke on problems and the relationship of his Bureau to physicians and pharmacists.

Seminole

The Seminole County Medical Society has paid 100 per cent of its state dues for 1954.

Taylor

The Taylor County Medical Society has paid 100 per cent of its state dues for 1954.

WANTED — FOR SALE

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

FOR SALE: Equipment and Practice. Excellent location with good lease. Active General Practice, Sarasota, Fla. Write 69-127, P.O. Box 1018, Jacksonville, Fla.

OBSTETRICIAN-GYNECOLOGIST: Board certified, age 35, married, University hospital training, Leaving service June 1955, Florida license, seeking association, group, or location. Write 69-131, P.O. Box 1018, Jacksonville, Fla.

FOR SALE: Mattern SRO-30 Shock-Proof Mobile X-ray Unit with darkroom and wall-mounted casette holder. New cost, $1,982. Will sell for $1,250. Write 69-132, P.O. Box 1018, Jacksonville, Fla.

FOR SALE: Both new, FCC Approved, Attractive Discounts. Shortwave LF 660 with accessories. Ultrasonic, console model. Previous uses of both only as demonstrators. Write 69-133, P.O. Box 1018, Jacksonville, Fla.

FOR SALE: 200 M.A. G.E. Diagnostic Unit, complete with motor drive table, spot film, rotating anode tube, all dark room equipment. A-1 condition throughout. Write 69-134, P.O. Box 1018, Jacksonville, Fla.

INTERNIST-ALLERGIST: Desires association or group. University training. Age 45. Florida license. Priority IV. Available immediately. Consider any opening. Write 69-135, P.O. Box 1018, Jacksonville, Fla.

GYNECOLOGIST: Desires full or part-time association with an individual group or clinic. Florida license. Write 69-136, P.O. Box 1018, Jacksonville, Fla.

OBITUARIES

Frederick Peter Swing

Dr. Frederick Peter Swing of Fort Lauderdale died at North Broward General Hospital in that city on May 2, 1954, after suffering a heart attack 12 days previously. He was 46 years of age.

Born in New Baltimore, Ohio, in 1908, Dr. Swing spent most of his life in his native state. He was awarded the degree of Doctor of Medicine by the University of Cincinnati College of Medicine in 1934 and then engaged in the practice of medicine in Cincinnati until coming to Fort Lauderdale in 1944. During the 10 years spent as a physician and surgeon in Fort Lauderdale, he was most active in medical circles and maintained a keen interest in civic affairs. Locally, he was a member of St. Anthony's Catholic Church, the Downtown Kiwanis Club, the Elks Lodge and the Coral Ridge Yacht Club. His fraternity was Sigma Chi.

Dr. Swing had been a member of the Broward County Medical Association and the Florida Medical Association since 1945. He was also a member of the American Medical Association.

Survivors include the widow, Mrs. Marguerite W. Swing, and two sons, Frederick P. Swing Jr., and James Edward Swing, all of Fort Lauderdale; the parents, Dr. and Mrs. Fred C. Swing, of Cincinnati; and one brother, James E. Swing, also of Cincinnati.

Ferdinand August Vogt

Dr. Ferdinand August Vogt of Miami died at his home in Coral Gables on May 3, 1954. He was 58 years of age. Interment took place in Atlanta, Ga.

Born in 1896, Dr. Vogt received his medical training at Emory University School of Medicine, where he was graduated in 1919. He then served as an instructor in anatomy at his alma mater. In 1925 he was licensed to practice medicine in Florida and located in Miami. His specialty was orthopedics. He devoted much time to aiding the crippled children of Dade County and accomplished much in their behalf. Endowed with many talents, when illness forced him to give up his favorite outdoor activity of fishing, he turned to art and completed a number of excellent paintings and portraits of his family. He was a gifted musician and played in name bands during his student days at Emory University. He was a Mason and a member of the Coral Gables Methodist Church and the Riviera Country Club.

Since 1926 Dr. Vogt had been a member of the Dade County Medical Association and the Florida Medical Association. He also held membership in the American Medical Association, Southern Medical Association, Southeastern Surgical Congress, American Geriatrics Society and Industrial Medical Association, and was a fellow of the American College of Surgeons.

Dr. Vogt is survived by his widow, Mrs. Marion Vogt, one son, William L. Vogt, and one daughter, Sharon Ann Vogt, all of Coral Gables; one brother, Albert G. Vogt, of Decatur, Ga.; and two sisters, Mrs. F. O. Beeker, of Chicago, and Mrs. Roger Alling, of Savannah, Ga.

Eugene Clayton Lowe

Dr. Eugene Clayton Lowe died at his home in Miami on July 2, 1954. He was 66 years of age.

A native Floridian, Dr. Lowe was born in Key West on May 18, 1888. He received his medical training at the University of Pennsylvania School of Medicine and was awarded the degree of Doctor of Medicine in 1912. Following his hospital training he entered the general practice of medicine in Key West in 1914.

During World War I Dr. Lowe served in the United States Navy and was stationed at the Naval Air Station in Key West. During the epidemic of 1918, he was active in the development of a treatment for pneumonia associated with influenza, which was credited with saving hundreds of lives.

Upon completion of his service in the Navy he established and operated a private hospital in Key West. In 1930 he moved to Miami and continued in the general practice of medicine there until he retired in 1952. For more than a decade he was a member of the staff of Jackson Memorial Hospital. The grandson of Mr. John Lowe, a great builder of boats and ship chandler of Key West, he had a great love of the sea and found recreation in boats. He was a Shriner, a member of the Elks Club and a member of the Miami Country Club.

Dr. Lowe was a member of the Dade County Medical Association. Since 1916 he had been a member of the Florida Medical Association, hold-

ing a life membership for the last four years. He was also a member of the American Medical Association.

He is survived by his widow, Mrs. Vergna N. Lowe; two sons, Eugene C. Lowe Jr., and Dr. William E. Lowe; a daughter, Mrs. John Davidson; and three grandchildren, all of Miami.

Charles Howell Ryals

Dr. Charles Howell Ryals of Dellwood and Grand Ridge died at Jackson Hospital in Marianna on May 3, 1954, following an illness of two weeks. He was 79 years of age.

Born in McRae, Ga., in 1875, Dr. Ryals received his medical training in his native state. In 1903 he was awarded the degree of Doctor of Medicine by the University of Georgia School of Medicine. That same year he was licensed to practice medicine in Florida and for more than 50 years engaged in the practice of general medicine and obstetrics in Jackson County. He continued to practice in Dellwood until just prior to his last illness. A member of the Methodist Church of Dellwood, he was also a member of Harmony Lodge No. 3, of which he was a past master, the Eastern Star, Shrine, Elks Lodge, and Woodmen of the World. Not long before his death he was signally honored by the citizens of Dellwood for his half century of service as valuable citizen and beloved physician.

Dr. Ryals was a member of the Jackson-Calhoun County Medical Society. Since 1904 he had held membership in the Florida Medical Association and was also a member of the American Medical Association.

Survivors include the widow, Mrs. Dannie Nichols Ryals, of Dellwood; four daughters, Mrs. M. B. Patrick Jr., of Bascom, Mrs. A. J. McMullian Jr., of Marianna, Mrs. T. B. McMullian, of Sneads, and Mrs. K. L. Kirkland, of Webb City, Ala.; and five sons, James C. Ryals, of Marianna, John Ryals, of Montgomery, Ala., Charles Howell Ryals Jr., Emmett E. Ryals and Albert W. Ryals, all of Dellwood.

Jerome Dever Stuart

Dr. Jerome Dever Stuart of Miami died at Jackson Memorial Hospital in that city on May 27, 1954. He was 63 years of age.

Dr. Stuart was born in Buckhannon, W. Va., in 1890. He received his medical degree from the Georgia College of Eclectic Medicine and Surgery in Atlanta in 1913, and that same year he was licensed to practice medicine in Florida. He located in Miami, where he practiced internal medicine until he retired in 1945.

Locally, Dr. Stuart was a member of the Westminster Presbyterian Church, Mahi Temple Shrine, Knights of Pythias, Eastern Star, Odd Fellows Lodge, Acacia Club and Mayflower Society, and was a life member of the Elks Lodge. He had been in ill health for some time and was depressed over the recent death of his mother, Mrs. Jerome W. Stuart, the last five years of his life having been devoted to her care.

Dr. Stuart was a member of the Dade County Medical Association. For 37 years he had been a member of the Florida Medical Association, holding honorary status for the past five years. He also held membership in the American Medical Association.

Surviving are two sisters, Mrs. Mabel S. Hendrix and Mrs. Wistar W. Gates, both of Miami, and two nieces and two nephews.

George Edmund Miller

Dr. George Edmund Miller of St. Petersburg died on July 14, 1954, at his summer cottage at Thousand Island Park, N. Y., where he had vacationed for many summers. He was 74 years of age.

Born in London, England, on Aug. 23, 1879, Dr. Miller came to the United States in childhood. After receiving the A.B. and M.A. degrees, he entered Columbia University College of Physicians and Surgeons, where he was awarded the degree of Doctor of Medicine in 1907. Because of ill health he was denied military service in World War I, but served on draft boards as examiner in both World Wars.

In 1920 Dr. Miller was licensed to practice medicine in Florida. The following year he located in St. Petersburg and engaged in the general practice of medicine there until shortly before his death.

Dr. Miller was a member of the Pinellas County Medical Society, served as its twentieth president, and repeatedly held staff offices and appointments. Since 1926 he had held membership in the Florida Medical Association and was also a member of the American Medical Association.

Surviving are the widow, Mrs. Gertrude Cobb Miller, four sons and one daughter.

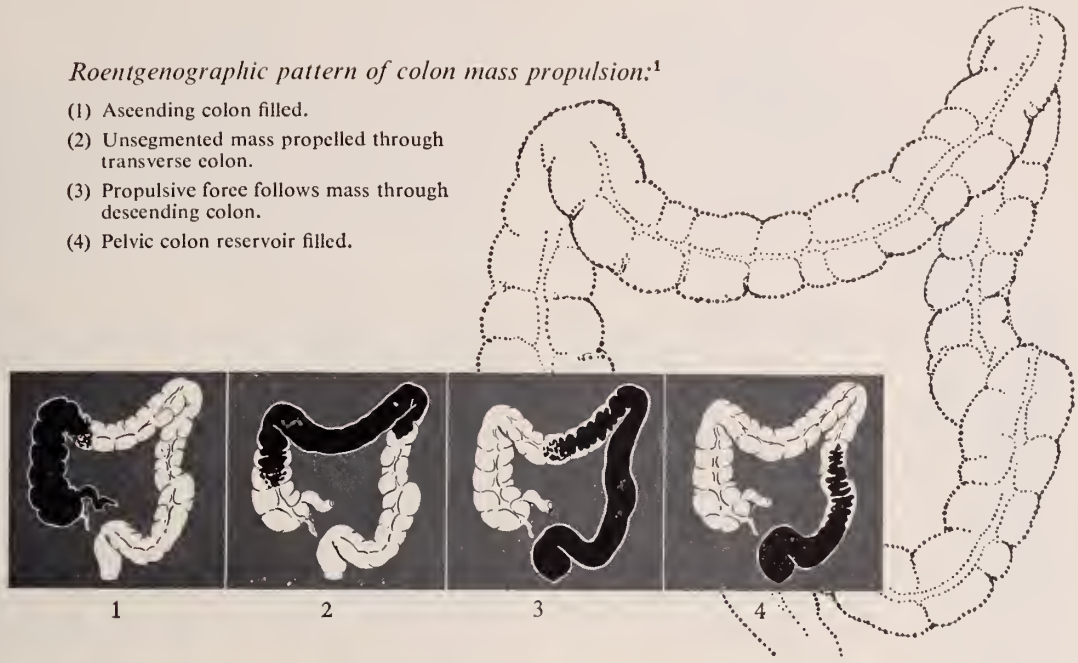
Roentgenographic pattern of colon mass propulsion:[1]

(1) Ascending colon filled.

(2) Unsegmented mass propelled through transverse colon.

(3) Propulsive force follows mass through descending colon.

(4) Pelvic colon reservoir filled.



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1. Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice: A Text in Applied Physiology, ed. 5, Baltimore, The Williams & Wilkins Company, 1950, pp. 579-583.

2. Bargen, J. A.: A Method of Improving Function of the Bowel, Gastroenterology *13*:275 (Oct.) 1949.



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Auxiliaries in Full Swing for Year

The component auxiliaries to the Woman's Auxiliary to the Florida Medical Association have started their yearly meetings and are already in full swing for the years work ahead. We thought you might be interested in what some of them are planning to do and what projects and programs they will be carrying on during the year. The job of the state Auxiliary is to advise and coordinate the work of the component auxiliaries and actually our report of the state is composed of the work of the various component auxiliaries throughout the year.

Over in District C, plans are in the making for a district meeting for Future Nurses' Clubs to be held on October 23, the medical auxiliaries of that district to sponsor this meeting. Plans are in the making to have similar meetings for Future Nurses' Clubs in the other districts in Florida in the near future. This program is under the direction of Mrs. Augustine S. Weekley, Nurse Recruitment Chairman of the state Auxiliary and also president of the Woman's Auxiliary to the Hillsborough County Medical Association.

In District D, the auxiliaries are looking forward to the Clinical Session of the American Medical Association which this year will be held November 29 through December 2 in Miami. Plans are being made for hospitality, tours for wives attending with their husbands, staffing of the Today's Health booth at both the Health Fair for the public which is to follow this session and at the professional exhibits during the session. The Dade County auxiliary is cooperating with the Dade County Medical Association in the work of the committees for this meeting and the hope is that there will be many Florida doctors and their wives who will take advantage of this fine program and session. Mrs. Robert F. Mikell, president of the D. C. M. A. auxiliary, and Mrs. Richard F. Stover, president of the F. M. A. Auxiliary, both of Miami, are cochairmen for the women's activities and the auxiliary. They share responsibility in this first Clinical Session to be held in Florida. There are no formal women's meetings planned although the president of the Woman's Auxiliary to the American Medical Association will be in attendance and will give her report to the A.M.A. House of Delegates.

In District A, plans are in the making by auxiliaries to follow the auxiliary program and special plans are being made by the Jackson-Calhoun auxiliary for the entertainment and meeting of the women at the District Meeting to be held in Marianna, October 11. Mrs. Jabe A. Breland, president of the Jackson-Calhoun auxiliary, is chairman for this project. We have heard rumors that the Leon-Gadsden-Liberty-Wakulla-Jefferson auxiliary is out to get over 200 per cent of their quota in Today's Health since their president, Mrs. T. Bert Fletcher, is also chairman for Today's Health for the state Auxiliary. They are hoping that all auxiliaries throughout the state will follow this example.

District B is making plans for their District Meeting in Sanford on October 13. Mrs. John M. Morgan, president, Seminole County auxiliary is chairman for this event and they are looking forward to having a large and enthusiastic crowd. Duval County is deep in helping the state auxiliary refurbish and furnish the nurses' home for Brewster School of Nursing, an accredited school of nurses for colored students. Mrs. S. James Beale, Public Relations Chairman for the state Auxiliary is in charge of this project and is being helped by Mrs. Samuel S. Lombardo, state President-elect, and by Mrs. G. Dekle Taylor, president, Duval County auxiliary.

Time and space do not allow the telling of all the projects of all the auxiliaries but we hope to include other special projects as the year goes by. We can assure you that all twenty-one of our organized auxiliaries are all working hard. We hope that by the end of this year our number will have grown and more of the doctors' wives from unorganized counties will have joined us in working for our husbands and better health.

Mrs. Richard F. Stover, President

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BOOKS RECEIVED

New and Nonofficial Remedies 1954. Issued under the Direction and Supervision of The Council on Pharmacy and Chemistry, American Medical Association. Pp. 609. Price, $2.65. Philadelphia, J. B. Lippincott Company, 1954.

New and Nonofficial Remedies is published annually to provide the physician with such information concerning the actions, usage, limitations, and dosage of acceptable and relatively new drugs as will promote the practice of rational therapeutics. Included are articles which the Council on Pharmacy and Chemistry of the American Medical Association has found acceptable under its rules through the period ending January 1 of the year of publication.

The book no longer carries the section on Tests and Standards for New and Nonofficial Remedies, which was first published separately in 1953 and will hereafter be published at three year to five year intervals rather than annually. Also, this year for the first time the section on Bibliography of Unaccepted Products was discontinued. The 1953 separate volume on Tests and Standards is available from the same publisher.

In order to keep pace with changes in therapeutics, New and Nonofficial Remedies is reviewed annually by the Council to revise the general statements and monographs and to eliminate those articles no longer considered useful. The book is available from the publisher, J. B. Lippincott Company, East Washington Square, Philadelphia 5, Pa.

Third Annual Report on Stress. By Hans Selye, M.D., Ph.D., D.Sc., F.R.S., and Alexander Horava, M.D. Pp. 637. Price, $10.00. Montreal, Canada, Acta, Inc., Medical Publishers, 1953.

This volume represents the third of a series of annual supplements published for the purpose of keeping up-to-date the monograph by the senior author entitled "Stress — The Physiology and Pathology of Exposure to Stress." It systematizes the data published throughout the world in the fields of biologic stress, the General Adaptation Syndrome (G-A-S), and the so-called "adaptive hormones." The authors believe that the critical evaluation of newly acquired data, and their prompt integration into the body of classic knowledge, is likely to promote progress even more than the discovery of any but the most fundamental new facts because the subject is comparatively new and yet has already affected almost every aspect of medicine. Within the comparatively short span of the last 17 years, during which the stress concept has taken shape, and particularly during the last four years since ACTH and glucocorticoids have become generally available, almost every physician has found it necessary to familiarize himself with some facet of this subject. Yet, in view of the rapidity with which this field develops, most interested persons are newcomers who have not yet had time to absorb this branch of science as an entity.

This entire series of reports, therefore, offers a classified guide system to approximately 20,271 references on stress, the adaptation syndrome and the adaptive hormones. The 1953 Report alone has 5,741 references.

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The scope of these reviews covers, in addition to stress research, such related subjects as, for example, the bioassay of corticoids, the metabolism of adrenalin, drugs affecting inflammation (in connection with local stress) or hypertension (viewed as a "disease of adaptation"). These reports are a combination of an extensive, classified index of new facts and a concise evaluation of the principal data, thereby accomplishing the two major aims of information and integration.

Beyond the Germ Theory, The Roles of Deprivation and Stress in Health and Disease. By Iago Galdston, M.D., editor. Pp. 182. Price, $4.00. New York, Health Education Council, 1954.

This New York Academy of Medicine book does not negate or deny the germ theory of disease. It goes beyond the germ theory and deals with factors other than germs that engender illness and poor health. It lays emphasis, in particular, on the disease-producing effects of deprivation and stress. This book therefore bears directly on the practice of clinical medicine, on public health, and on health education. The contents derive from the 12th Annual Eastern States Health Education Conference sponsored by The New York Academy of Medicine. The material originally presented has been extended, revised and integrated to give a balanced and well rounded statement of the effects of deprivation and stress on health and disease. It is divided into four parts: The Dynamics of Deprivation and Stress, Nutritional Deprivation and Stress, Psychological Deprivation and Stress, and Social Stress and Deprivation.

The reader, however, will perceive that the subject matter can be reorganized in the chronologic pattern of the life span; for the effects of deprivation and stress operate at all age levels, from the prenatal period through old age. Chapter 5, for example, deals with the results of nutritional deprivation of the pregnant woman on her infant and relates such deprivation to the problem of prematurity. Chapter 8 gives a graphic picture of the unhappy and often fatal outcome of emotional deprivation in infancy. Chapter 9 sets forth the effects of normal stress on normal experience. Chapter 6 places emphasis on nutritional needs in old age.

This volume propounds and extends the concepts of Claude Bernard, Walter Cannon, and Hans Selye — of the "internal milieu," of "homeostasis," and of "the stress syndrome." How these concepts, born of research philosophy, can now be successfully applied to the prevention and treatment of disease and the promotion of health is, in effect, the theme and substance of this book.

The Mechanism of Inflammation, An International Symposium. Edited by G. Jasmin, M.D., and A. Robert, M.D. Pp. 308. Price, $8.50. Montreal, Canada, Acta, Inc., Medical Publishers, 1953.

This monograph sets forth the views of the greatest contemporary investigators in the field of inflammation as expressed in a Symposium held in Montreal, Canada, in early September 1953 on the occasion of the XIX International Physiological Congress. This first international symposium on inflammation made possible the coordination of the major contributions of the last 20 years in this field, such as further evidence of the role of histamine, data on the chemical constitution of the ground substance and the spreading factors, greater clarification of the chemical mediators, and discovery of the prophylogistic and antiphlogistic actions of hormones, which, in spite of disparities, can all be related to a single phenomenon: inflammation. In order to achieve a synthesis of all up-to-date factors involved in the development of an inflammatory reaction, specialists were called in from several countries, namely, Belgium, Brazil, Canada, France, Germany, India, Italy, Japan and the United States.

The authors offer in the preface this critical analysis of the Symposium: "All those present heard the greatest contemporary authorities on inflammation express their views on this subject; the underlying mechanisms were discussed and many experiments described, so that it can be stated that a great deal has been learned on this occasion. However, one could detect a serious divergence of opinion among the experts. For instance, some claim that without histamine there is no inflammation; others state that vessels play a prominent, if not exclusive, role; others again ascribe particular importance to the constituents of the ground substance; finally, each participant gives a different definition of inflammation. Undoubtedly, these various hypotheses represent part of the truth, and yet one is inclined to consider that these specialists, in looking at only one aspect of the problem, have not arrived at a stage where synthesis is possible . . . . many *facts* have been accumulated, but many *links* are still missing. This is indeed the situation in 1953."

(Continued on page 317)

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(Continued from page 315)

Let's Eat Right to Keep Fit. By Adelle Davis, A.B., M.S., Pp. 322. Price, $3.00. New York, Harcourt, Brace and Company, 1954.

This new book by the author of Let's Cook It Right and Let's Have Healthy Children will be widely read and used in the home as a guide to better living. It is a simple, sound, and above all practical guide to the principles of nutrition. "Nutrition is a personal matter," says Miss Davis, "as personal as your diary or income-tax report. Your nutrition can determine how you look, act, and feel; whether you are grouchy or cheerful, homely or beautiful, whether you think clearly or are confused, enjoy your work or make it a drudgery."

This book is designed to help any normal adult find his or her way to maximum fitness through proper diet. It discusses the 60 or more nutrients needed by the body to build health, and tells what foods supply these nutrients in the most concentrated form. The essential vitamins and minerals are dealt with in detail, and their function in the body analyzed according to the most up-to-date medical information. There are specific recommendations for a balanced diet supplying adequate quantities of all these vital substances. In a final section, the author discusses the general aspects of the nutrition problem, and tells what the individual can do to help build national health.

Miss Davis, formerly a dietitian at Bellevue Hospital in New York City, is at present a consulting nutritionist in Los Angeles.

Recent Advances in Cardiovascular Physiology and Surgery, A Symposium Presented by the Minnesota Heart Association and the University of Minnesota. Pp. 132. Paper binding. Price, $1.00. St. Paul, Minnesota Heart Association, 1954.

This composite bound volume of the proceedings of a Heart Symposium presented by the Minnesota Heart Association and the University of Minnesota was published in Minnesota Medicine, January, February and March 1954, thus making it possible for reprints of the complete proceedings to be available for general distribution. This symposium brings together the important contributions of a representative group of investigators from parts of the United States, Canada and Europe, and was designed to include discussion of the various aspects of new knowledge in cardiovascular physiology and surgery. A valuable addition to any physician's or surgeon's library, this book should be of particular interest to those specializing in cardiology.

Subjects covered in the symposium are: Heart Muscle Contraction, Regulation of Circulation, Measurements of Pressure and Flow, Differential Diagnosis of Various Defects by Physiologic Means, Recent Advances in Surgical Treatment of Heart Disease and the Physiology on Congestive Failure of the Circulation.



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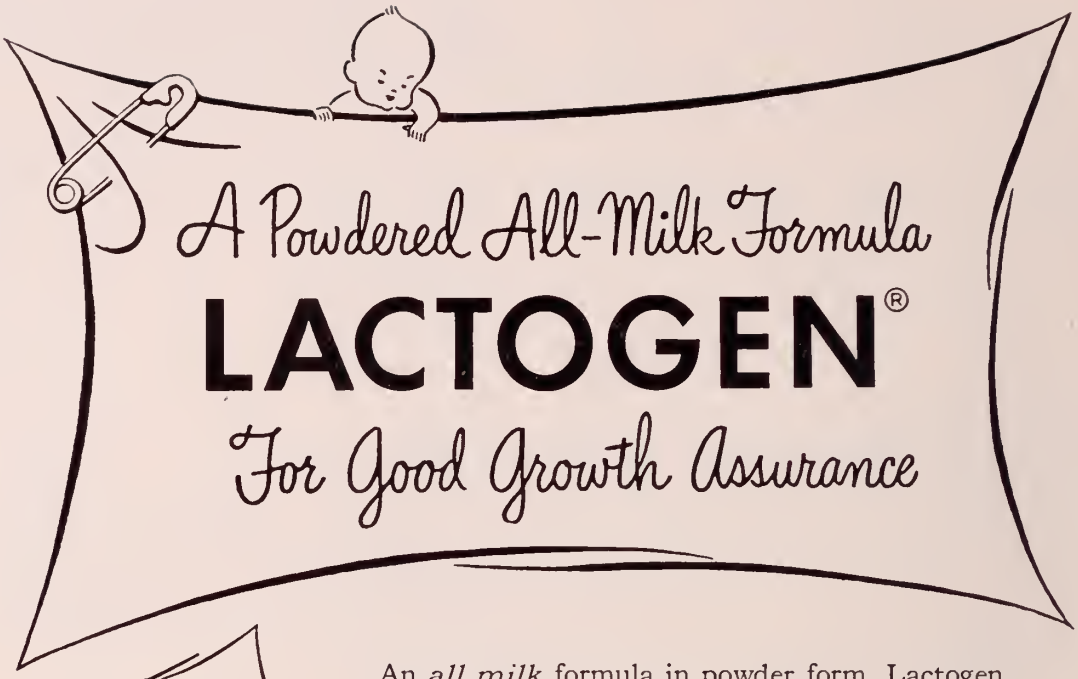
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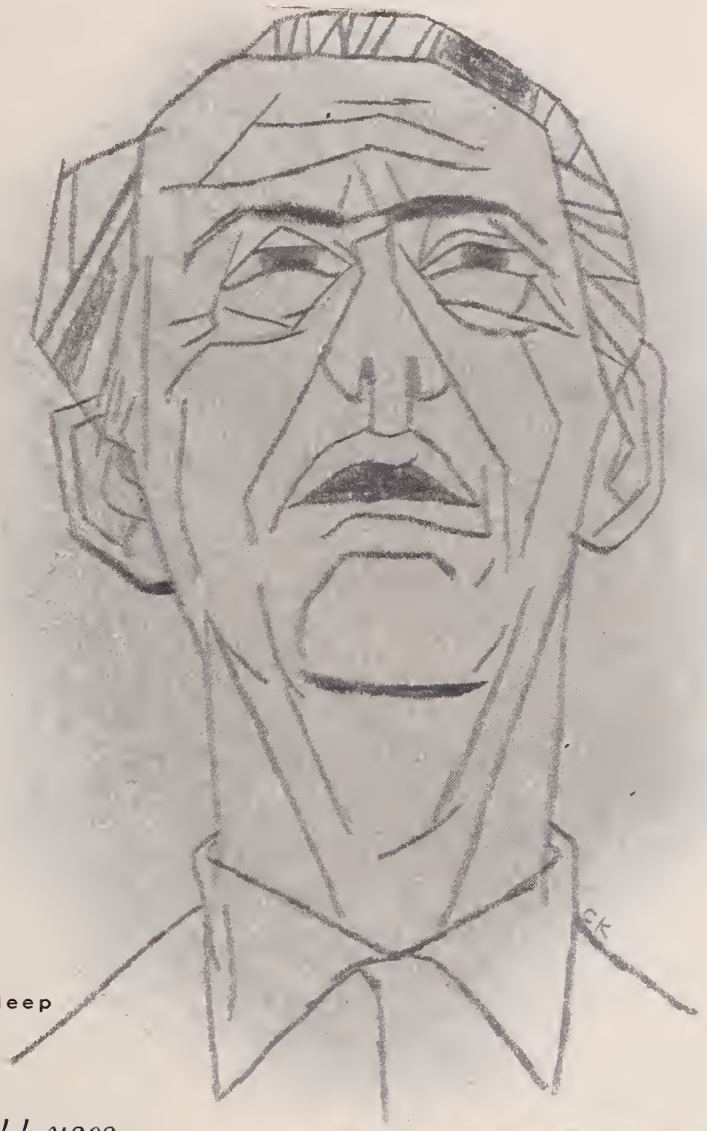
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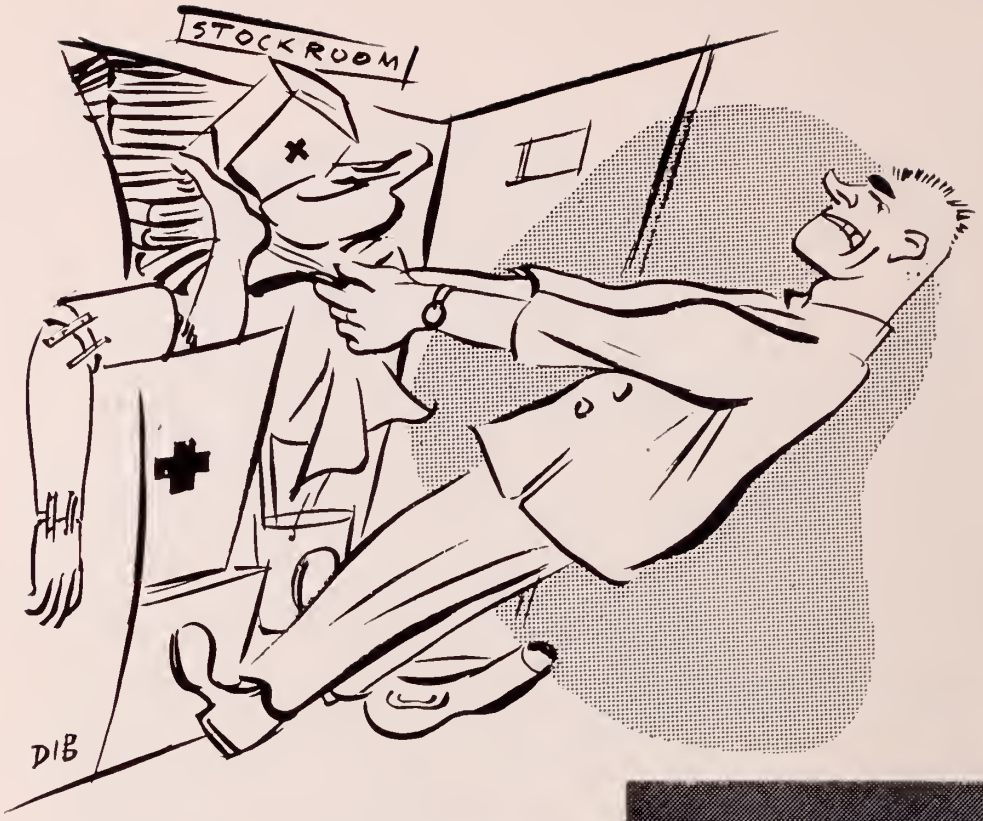
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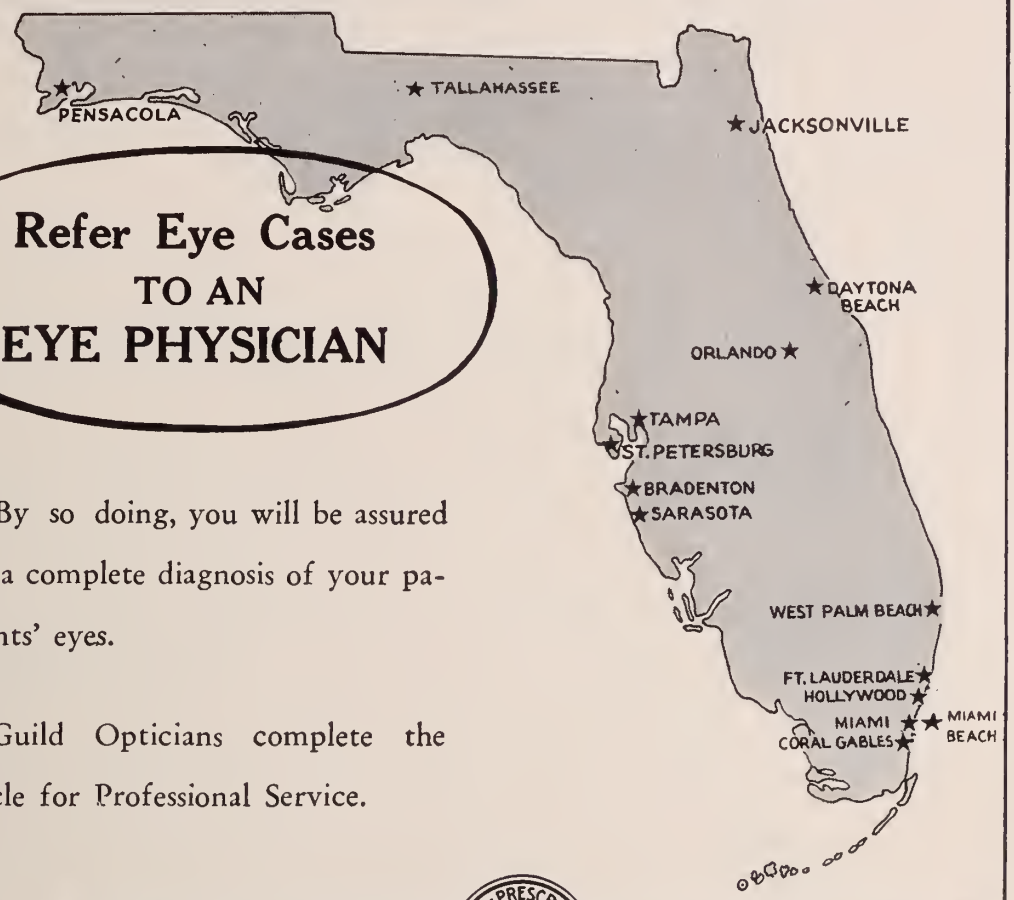
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Fort Pierce	William Franklin	106 N. 4th St.
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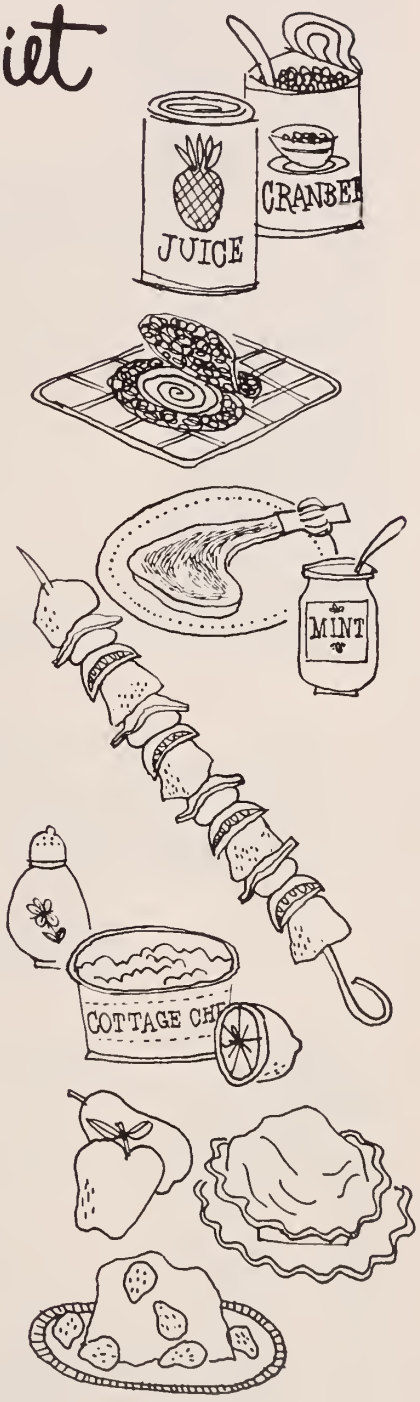
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Meat loaf can sport a gay cap of whole-cranberry sauce, while hamburgers make a surprise party when a slice of pickle or onion is sealed between two thin patties. Your patient can baste chicken with lemon or orange juice—glaze lamb chops with mint jelly. Lean meats, broiled or baked, are made savory with herbs. And barbecued kabobs add something different.

Most vegetables can be dressed simply with lemon juice or an herb vinegar. And tomato halves come out from under the broiler bubbly with brown sugar and sweet basil on top.

On green salads, cottage cheese thinned with lemon juice, sparked with paprika, makes the dressing. And on fruits, try lemon juice, honey and chopped mint.

For dessert, angel cake or meringue shells go nicely under fruits—skim milk powder makes the "whipped cream." Snow pudding is a simple dessert—fresh fruit, even more so. And for a change, your patient may like his fruit baked in grape or cranberry juice.

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Hialeah	1210 Pacific Bldg.	Tampa	228 Cass Street Arcade Building
St. Petersburg	509 White Building	Sarasota	1369 Main Street, Room 15
Lakeland	206 Marble Arcade	Daytona Beach	116½ Orange Avenue
West Palm Beach	305 Citizens Building	Pensacola	501 Theisen Building

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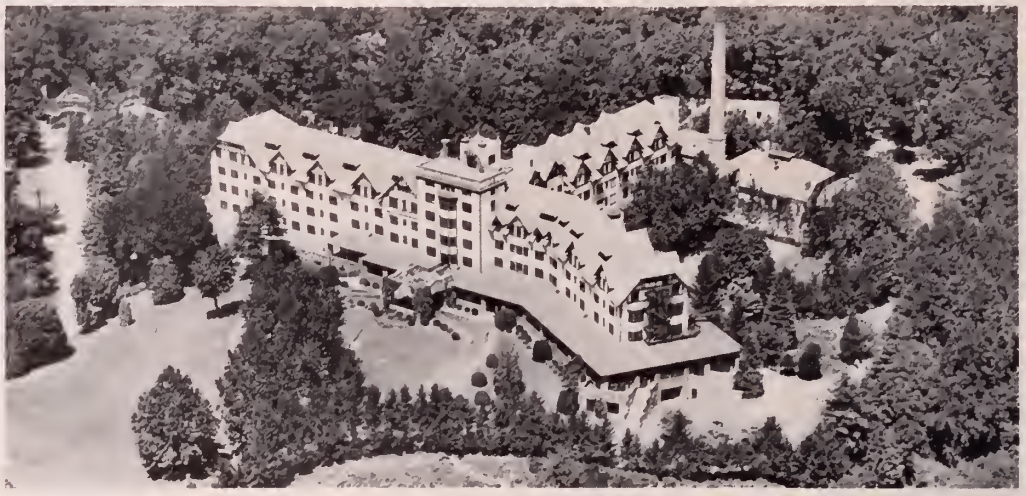
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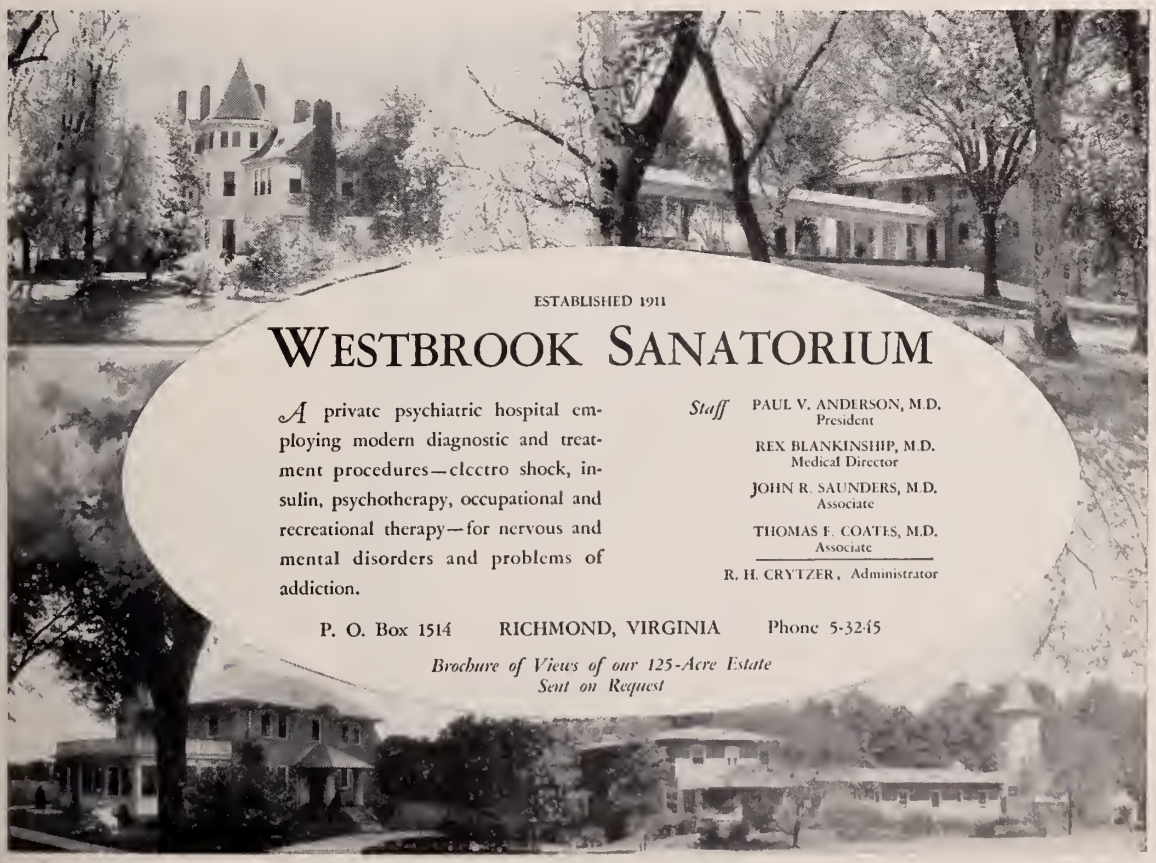
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
rida Medical Association	Duncan T. McEwan, Orlando	Samuel M. Day, Jacksonville	St. Petersburg, Apr. 3-6, '55
rida Medical Districts	Francis H. Langley, St. Petersburg	Council Chairman	
-Northwest	William H. Hixon, Pensacola	George S. Palmer, Tallahassee	Marianna, Oct. 11, '54
-Northeast	Henry J. Babers Jr., Gainesville	Thomas C. Kenaston, Cocoa	Sanford, Oct. 13, '54
-Southwest	Clyde O. Anderson, St. Petersburg	James R. Boulware Jr., Lakeland	Sarasota, Oct. 15, '54
-Southeast	James R. Sory, West Palm Beach	Russell B. Carson, Ft. Lauderdale	Vero Beach, Oct. 14, '54
rida Specialty Societies			
dersy of General Practice	Leonard L. Weil, Miami Beach	Leon S. Eisenman, Hialeah	St. Petersburg, Apr. 3, '55
rgy Society	Solomon D. Klotz, Orlando	Edwin P. Preston, Miami	" "
sthesiologists, Soc. of	R. Gaylord Lewis, West Palm Beach	Harry E. Bierley, West Palm Beach	" "
st Phys., Am. Coll., Fla. Chap.	DeWitt C. Daughtry, Miami	Jack Reiss, Coral Gables	" "
m. and Syph., Assn. of	Hollis F. Garrard, Miami	Joseph A. J. Farrington, Jacksonville	" "
lth Officers' Society	Thomas E. Morgan, Jacksonville	Lorenzo L. Parks, Jacksonville	" "
ustrial and Railway Surgeons	Plumer J. Manson, Miami	John H. Mitchell, Jacksonville	" "
rology & Psychiatry	Sullivan G. Bedell, Jacksonville	Roger E. Phillips, Orlando	" "
and Gynec. Society	Harold G. Nix,Tampa	Reuben B. Chrisman Jr., Miami	" "
thal. & Otol., Soc. of	G. Tayloe Gwathmey, Orlando	Carl S. McLemore, Orlando	" "
hopedic Society	John F. Lovejoy, Jacksonville	Newton C. McCollough, Orlando	" "
hologists, Society of	Millard B. White, Sarasota	James B. Leonard, Tampa	" "
liatric Society	C. Jennings Derrick, W. Palm Bch.	Wesley S. Nock, Coral Gables	St. Petersburg Bch., Oct. 22-24, '54
ctologic Society	Claude G. Mentzer, Miami	George Williams Jr., Miami	St. Petersburg, Apr. 3, '55
diological Society	A. Judson Graves, Jacksonville	James T. Shelden, Lakeland	" "
geons, Am. Coll., Fla. Chapter	Frederick J. Waas, Jacksonville	C. Frank Chunn, Tampa	" "
logical Society	Linus W. Hewit, Tampa	Frank J. Pyle, Orlando	" "
rida—			
Basic Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, Nov. 6, '54
Blood Banks, Association	John T. Stage, Jacksonville	John B. Ross, Jacksonville	St. Petersburg, 1955
Blue Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	Palm Beach Shores, Nov. 17, '54
Blue Shield of Florida, Inc.	David R. Murphey Jr., Tampa	Jack O. W. Rash, Miami	
Cancer Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	St. Petersburg, Apr. 3, '55
Clinical Diabetes Assn.	Fred Mathers, Orlando	Edward R. Smith, Jacksonville	Orlando, Oct. 21-22, '54
Dental Society, State	Robt. Thoburn, D.D.S.,Daytona Bch	J. E. Edwards, D.D.S., Coral Gables	Jacksonville, Apr. 23-25, '55
Heart Association	Alvin E. Murphy, Palm Beach	Daniel R. Usdin, Jacksonville	April 1955
Hospital Association	Mr. J. F. Wymer Jr., W. Palm B.	Mrs. Mary Reeder, Miami	Palm Beach Shores, Nov. 18-19, '54
Medical Examining Board	Frank D. Gray, Orlando	Homer L. Pearson Jr., Miami	Jacksonville, Nov. 21-23, '54
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
Nurse Anesthetists, Fla. Assn.	Miss Dorothy Jackson, C. Gables	Mrs. Lulla F. Bryan, Miami	Palm Bch. Shores, Nov. 17-19, '54
Nurses Association, State	Mrs. Bertha King, Tampa	Mrs. Idalyn Lawthon, Tampa	Jacksonville, Oct. 30-Nov. 3, '54
Pharmaceutical Association, State	Mr. J. L. McDonald, St. Augustine	Mr. R. Q. Richards, Ft. Myers	Clearwater, May '55
Public Health Association	Frank M. Hall, Gainesville	Mr. Fred B. Ragland, Jacksonville	Miami Beach, Oct. 21-23, '54
Trudeau Society	Lawrence C. Manni, Tallahassee	Simon D. Doft, Jacksonville	May, 1955
Tuberculosis & Health Assn.	Judge Ernest E. Mason, Pensacola	Mrs. L. C. Conant, Fort Myers	
Woman's Auxiliary	Mrs. Richard F. Stover, Miami	Mrs. S. J. Wilson, Ft. Lauderdale	St. Petersburg, Apr. 3, '55
erican Medical Association	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	Atlantic City, June 6-10, '55
A.M.A. Clinical Session	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	Miami, Nov. 29-Dec. 2, '54
uthern Medical Association	Alphonse McMahon, St. Louis	Mr. C. P. Loranz, Birmingham	St. Louis, Nov. 8-11, '54
bama Medical Association	J. M. Donald, Birmingham	Douglas L. Cannon, Montgomery	Montgomery, Apr. 21-23, '55
orgia, Medical Assn. of	Peter B. Wright, Augusta	David Henry Poer, Atlanta	Augusta, May 1-4, '55
E. Hospital Conference	Mr. John W. Gill, Vicksburg, Miss.	Mr. Pat Groner, Pensacola	Atlanta, Apr. 20-22, '55
utheastern Allergy Assn.	W. L. Rucks, Memphis, Tenn.	Kath. B. MacInnis, Columbia, S. C.	Orlando, 1955
utheastern, Am. Urological Assn.	Sam L. Raines, Memphis, Tenn.	Robert F. Sharp, New Orleans	New Orleans Mar. 20-23, '55
utheastern Surgical Congress	J. Duffy Hancock, Louisville, Ky.	B. T. Beasley, Atlanta	Atlanta, Mar. 7-10, '55
lf Coast Clinical Society	Jas. N. Lockard, Pascagoula, Miss.	F. C. Minkler, Pascagoula, Miss.	Edgewater Park, Miss., Oct.



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County Medical Societies of Florida

SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Total Members
Alachua	Henry H. Graham, Gainesville	Glenn O. Summerlin, Gainesville	2nd Tues.	51
**Bay* *Bradford, Gilchrist, Union*	Lemuel F. Coxe Jr., Panama City	James D. Nixon, Panama City	1st Tues.	25
Brevard	Theodore J. Kaminski, Melbourne	Paul L. Summers, Melbourne	2nd Tues.	28
Broward	Julius F. Boettner, Fort Lauderdale	George T. F. Rahilly, Fort Lauderdale	4th Tues.	111
Columbia	Robert B. Harkness, Lake City	Thomas H. Bates, Lake City	1st Mon.	12
**Dade* *Baker, Hamilton*	Edward W. Cullipher, Miami	Kenneth S. Whitmer, Miami	1st Tues.	673
DeSoto-Hardee-Highland-Glades	Carl J. Larsen, Avon Park	Samuel A. King, Avon Park	2nd Tues.	27
Duval	Karl B. Hanson, Jacksonville	Jackson L. Allgood Jr., Jacksonville	1st Tues.	275
**Escambia* *Clay*	Wilton E. Tugwell, Pensacola	Paul F. Baranco, Pensacola	2nd Tues.	102
**Franklin-Gulf* *Santa Rosa*	Albert L. Ward, Port St. Joe	Warren T. Weathington, Apalachicola	Last Wed.	9
Hillsborough	C. Frank Chunn, Tampa	Julien C. Pate Jr., Tampa	1st Tues.	181
Indian River	William L. Fitts 3rd, Vero Beach	Vernon L. Fromang, Vero Beach	2nd Tues.	10
Jackson-Calhoun	Jabe A. Breland, Marianna	Francis M. Watson, Marianna	Quarterly	17
Lake	J. Basil Hall, Tavares	James R. Hanson, Tavares	1st Wed.	29
**Lee-Charlotte-Collier-Hendry* *Sumter*	H. Quillian Jones, Fort Myers	James L. Bradley, Fort Myers	3rd Mon.	37
Leon-Gadsden-Liberty-Wakulla-Jefferson	George H. Massey, Quincy	Odis G. Kendrick Jr., Tallahassee	Quarterly	60
Madison	Wallace E. Winter, Madison	Julian M. DuRant, Madison		5
Manatee	Willett E. Wentzel, Bradenton	Marjorie L. Warner, Bradenton	2nd Tues.	25
**Marion* *Levy*	William H. Anderson Jr., Ocala	Bertrand F. Drake, Dunnellon	3rd Tues.	30
Monroe	Edward Gonzalez, Key West	Herman K. Moore, Key West	2nd Thurs.	12
Nassau	David G. Humphreys, Fernandina	John W. McClane, Fernandina	Last Fri.	11
**Orange* *Osceola*	Eugene L. Jewett, Orlando	Andrew W. Townes Jr., Orlando	3rd Wed.	181
Palm Beach	Thomas E. Daly, West Palm Beach	David A. Newman, Palm Beach	4th Mon.	134
Pasco-Hernando-Citrus	Frank Y. Robson, New Port Richey	W. Wardlaw Jones, Dade City	2nd Thurs.	18
Pinellas	Alvin L. Mills, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	217
Polk	Theodore C. Keramidas, Winter Haven	James T. Shelden, Lakeland	2nd Wed.	91
Putnam	Lawrence G. Hebel, Palatka	James A. Long Jr., Palatka	2nd Tues.	10
St. Johns	James J. DeVito, St. Augustine	Reuben J. Plant Jr., St. Augustine	3rd Tues.	19
St. Lucie-Okeechobee-Martin	Laurance D. Van Tilborg, Ft. Pierce	Adrian M. Sample, Fort Pierce	3rd Thurs.	21
Sarasota	Henry J. Vomacka, Sarasota	Lloyd J. Duest, Sarasota	2nd Tues.	53
Seminole	J. Clifford Boyce, Sanford	Terry Bird, Sanford	2nd Tues.	20
Suwannee	William P. Blackmon, Mayo	Hiram B. Curry, Jasper	1st Sat.	9
**Taylor* *Dixie, Lafayette*	George H. Warren, Perry	Walter J. Baker, Foley	Last Fri.	4
**Volusia* *Flagler*	Cleland D. Cochrane, Daytona Beach	Robert L. Miller, Daytona Beach	2nd Tues.	85
Walton-Okaloosa	Robert von P. Maxon, Fort Walton	Arthur G. Williams Jr., Valparaiso	3rd Thurs.	20
Washington-Holmes	Ralph H. Segrest, Bonifay	Baylye W. Dalton, Chipley		6
			Total	2,618

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Recent physiological and clinical research confirms its adjunctive value in the diet of many patients

THE WIDE recommendation of wine as a gentle and pleasant stimulus to appetite, digestion, and the full enjoyment of a meal, has a sound basis in the findings of controlled research.

Results of some recent studies* are the following:

Influence of Wine on Appetite—Two wineglassfuls of 20 per cent alcohol (the concentration in the usual appetizer or dessert wine) have been found to relieve prolonged gastric tension. Two or three ounces of dry table wine can markedly increase the olfactory acuity and the appetite in anorexia, and stimulate caloric intake.

The Buffer Action of Wine in Digestion—The effect of wine on free and total gastric acidity is slower and more prolonged than that of plain alcohol. Because of the buffering action of its phosphates, organic acids and tannins, wine induces a less violent but more sustained increase in gastric secretion and gastric motility.

Wine Stimulates the Flow of Pepsin—Ingestion of moderate amounts of wine, notably white table wine, has been found to increase appreciably not only the volume but the proteolytic power of gastric juice.

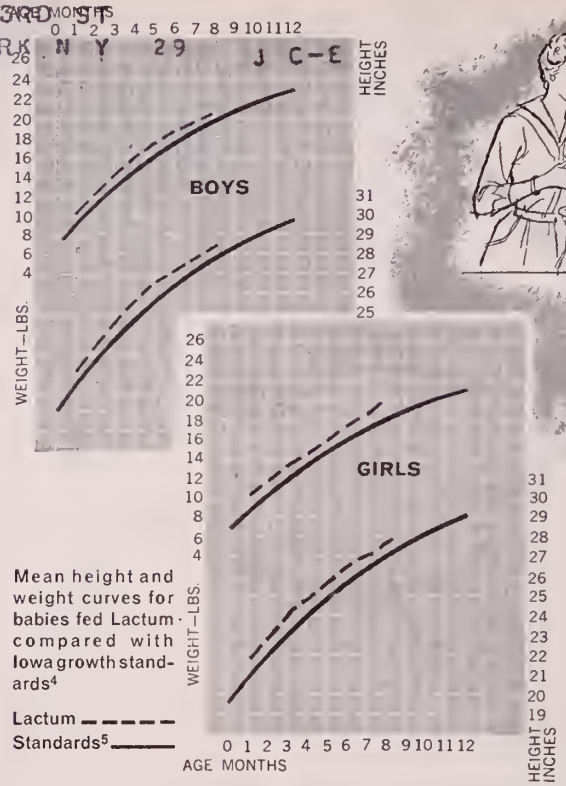
Wine in the Diet of Oldsters and Convalescents—There are sound, physiological reasons, therefore, why the generally lax and achlorhydric stomach of older people and convalescents reacts favorably to the mild, secretory stimulation of wine taken at mealtimes. And wine offers other valuable vasodilating, soothing, relaxing effects . . . a little Port or sherry wine at bedtime is a valuable aid to normal sleep, and may obviate the need for sedative medication.

Wine to Brighten the Monotonous Diet—In the dull and often unappealing dietary regimen of many patients, a glass of wine can frequently provide a touch of interest and "elegance"—a psychological boost of inestimable value.

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Mean height and weight curves for babies fed Lactum compared with Iowa growth standards[4]

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(1) Jeans, P. C.: In A.M.A. Handbook of Nutrition, Ed. 2, Philadelphia, Blakiston, 1951, p. 275. (2) Albanese, A. A.: Pediat. 8: 455, 1951. (3) Holt, L. E., Jr., and McIntosh, R.: In Holt Pediatrics, Ed. 12, New York, Appleton-Century-Crofts, Inc., 1953, pp. 175-178. (4) Frost, I. H., and Jackson, R. L.: J. Pediat. 39: 585, 1951. (5) Jackson, R. L., and Kelly, H. G.: J. Pediat. 27: 215, 1945.

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The Journal OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XLI NOVEMBER, 1954 No. 5

A. M. A. CLINICAL SESSION ISSUE

Rheumatic Fever In Subtropical Climate
Milton S. Saslaw

Solitary Discrete Pulmonary Densities
George H. McSwain

Diamondback Rattlesnake Bite
Harry F. Watt and C. B. Pollard

From Our President
Duncan T. McEwan

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MIAMI, NOV. 29 - DEC. 2, 1954

(See Page 381)

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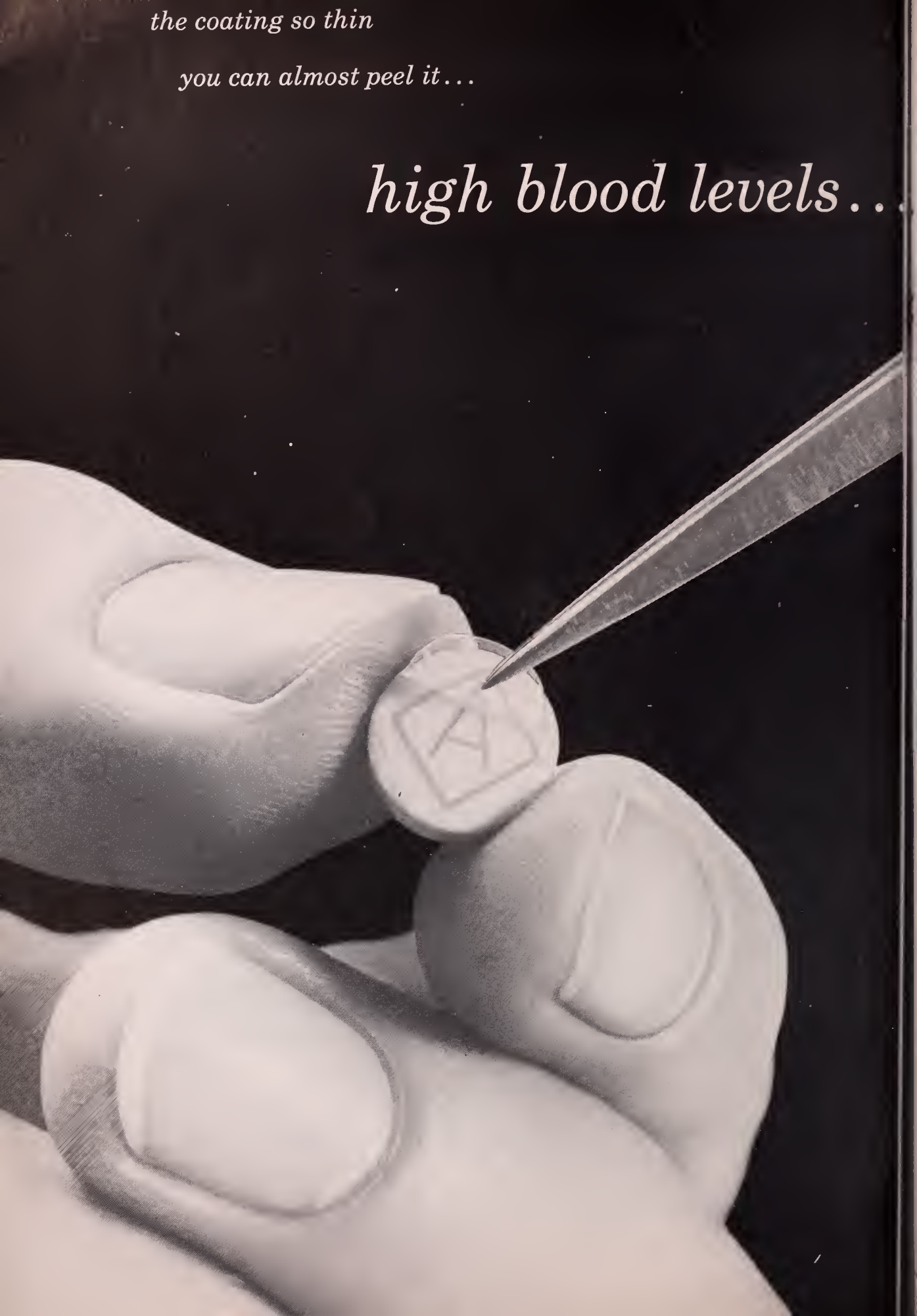
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1. Werner, A.: Acta endocrinol. *13*:87, 1953.
2. Malleson, J.: Lancet *2*:158 (July 25) 1953.
3. Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc., 1953, p. 23.

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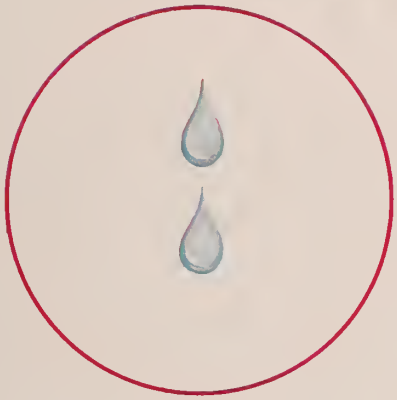
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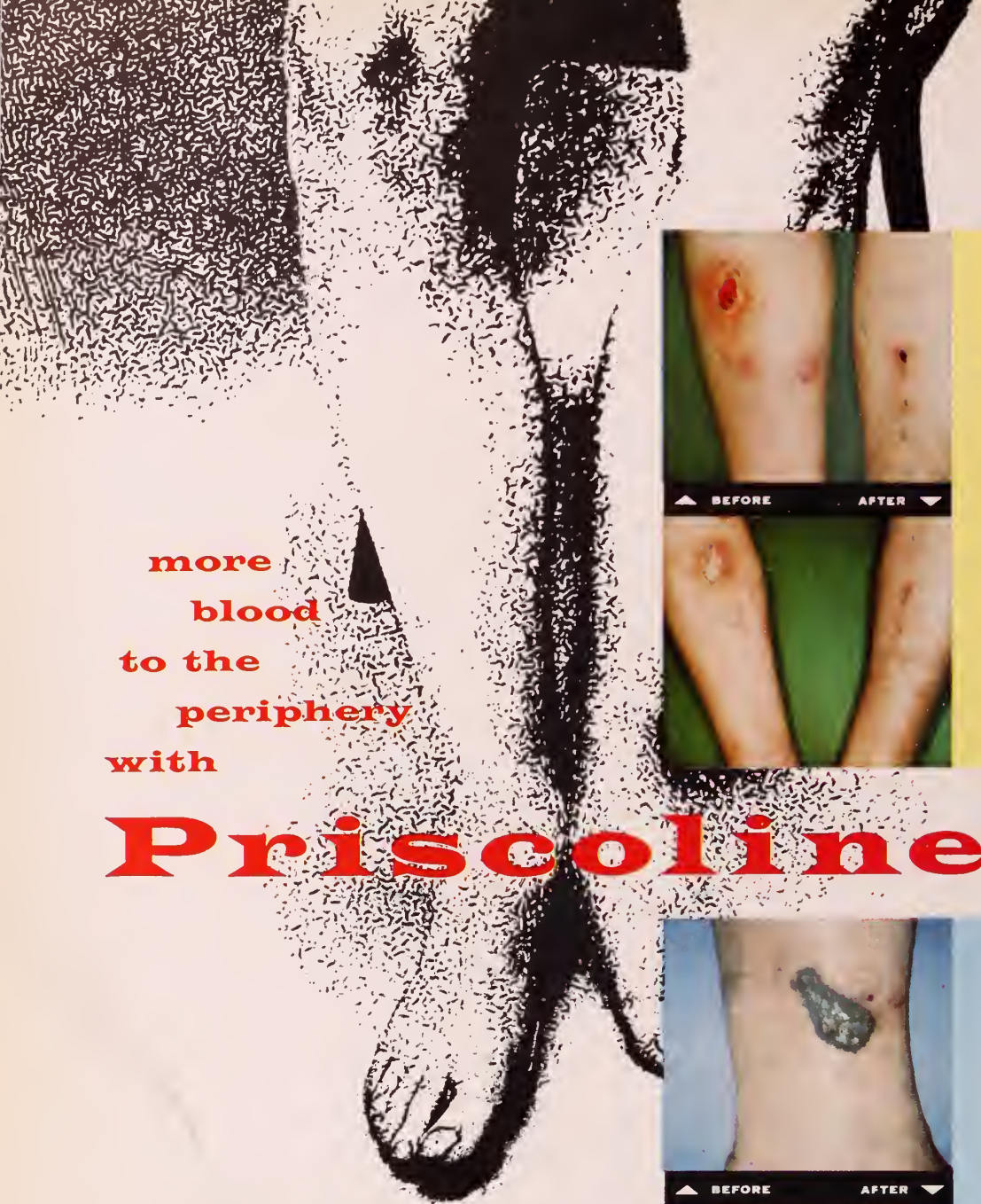
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Dihydrostreptomycin	6	0	6
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	Mild	*Moderate*	*Total*
Streptomycin	0	0	0
Dihydrostreptomycin	12	3	15
Distrycin	0	0	0

**Heck, W.E.; Lynch, W.J., and Graves, H.L.: Acta oto-laryng. 43:416, 1953.*

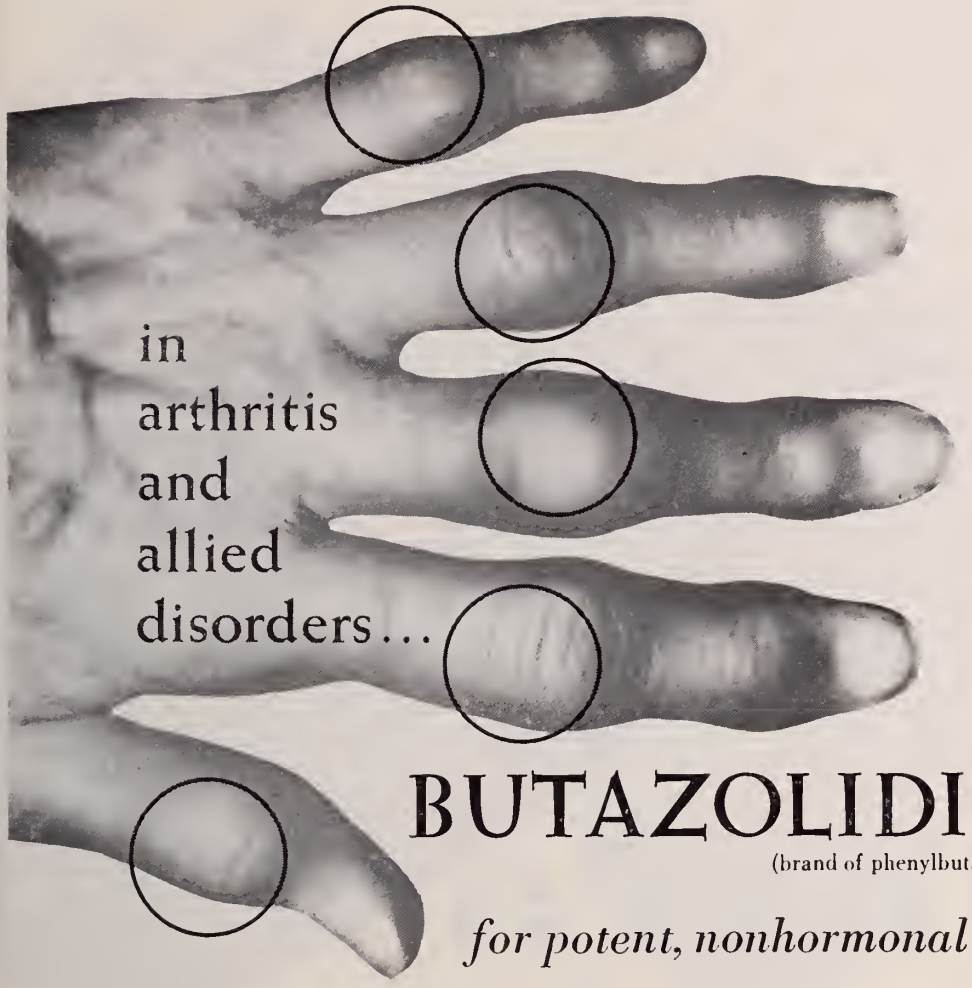
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*MacKnight, J. C.; Irby, R., and Toone, E. C., Jr.: Geriatrics 9:111 (Mar.) 1954.

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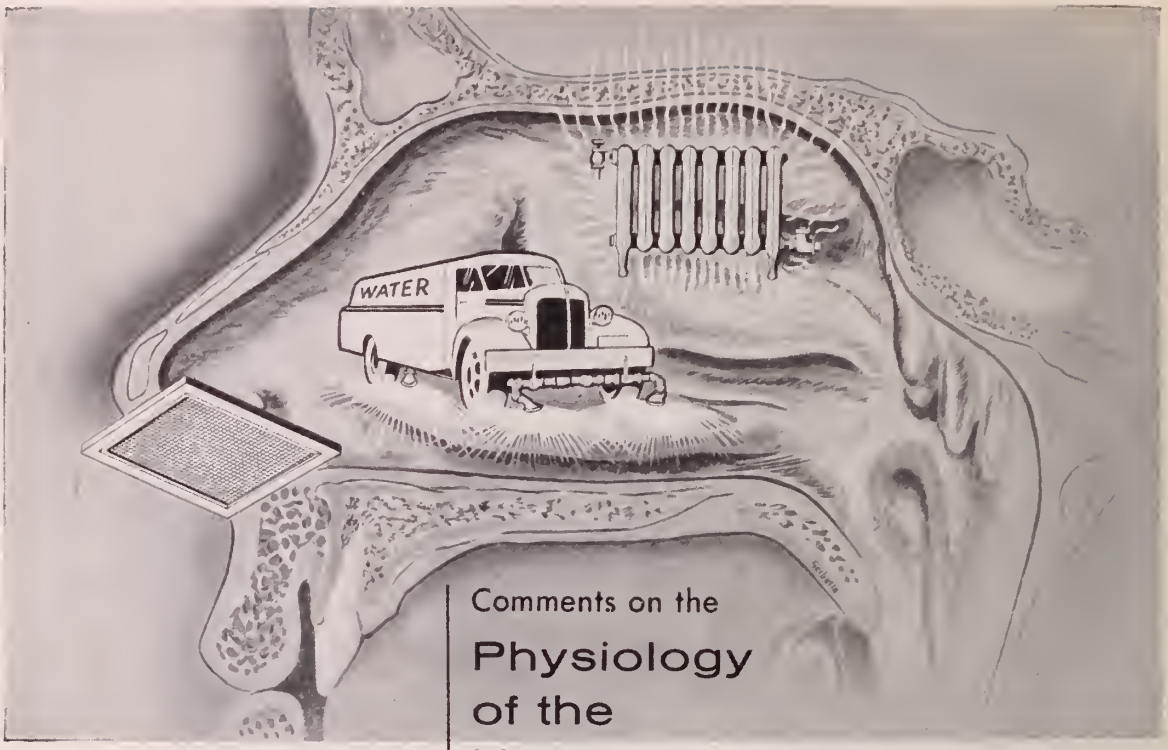
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Comments on the

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XLI | Jacksonville, Florida, November, 1954 | No. 5

Rheumatic Fever in a Subtropical Climate: Clinical Behavior and Management

MILTON S. SASLAW, M.D.
MIAMI

Those of us who practice medicine in the state of Florida are aware that rheumatic fever and rheumatic heart disease do not behave in the same manner there as in northern areas. For several years, my associates and I have been interested in the differences in the rheumatic picture in Florida as compared with that farther north. In our studies, we have attempted to determine the nature of and explanations for these variations.

In the subtropical climate of Florida, rheumatic fever is less common and less severe. Rheumatic heart disease, as has been shown by us,[1] in Dade County, and by Graybiel and his co-workers,[2] in Escambia County, is less than half as frequent as elsewhere in the United States, with the exceptions of southern Arizona[3] and Redlands, Calif.[4]

Table 1 shows the prevalence of rheumatic heart disease per thousand school children in northern states. Table 2 shows corresponding figures for southern areas. Table 3 is a composite of these data. The rate per thousand for the North varies between 16.3 and 45.0, while in the South it is 3.8 to 5.0. It is apparent that Florida has an advantage.

We found further evidence of this difference in a study[7] of the records of 1,909 children seen in the Outpatient Clinic of the National Children's Cardiac Hospital in Miami. Among native-born Floridians there was much less rheumatic heart disease than among those born outside the state of Florida. Rheumatic heart disease was 5.3 times more prevalent in white non-Floridians (table 4).

Read before the Florida Medical Association, Eightieth Annual Meeting, Hollywood, April 26, 1954.

We have also observed over a 14 year period at this hospital that recurrences of rheumatic fever are infrequent. Robinson and Currens,[8] in 1946, reported 7 recurrences (7.9 per cent) in 88 children hospitalized there. This was a low rate at that time. Since 1946, Dr. Hernandez and I have noted only 10 recurrences (3.7 per cent) in 272 patients. This low recurrence rate also was observed in a study of the medical records of three large hospitals in the Miami area where, during the five year period from 1947 to 1952, I found record of only 32 admissions for active rheumatic fever.

Table 1.—Rheumatic Heart Disease Prevalence: Northern Climates

Place	Report	Rate/1000
Colorado (Denver)	Wedum[5] (1945)	16.3
Montana, Wyoming	Paul[3] (1937)	45.0
Wisconsin (Madison)	Quinn[6] (1952)	22.0
California (Eureka)	Sampson[4] (1945)	20.0

The lower incidence of rheumatic heart disease and the infrequency of recurrences in the subtropical climate of Florida, we concluded, reflect differences in the etiology, manifestations and diagnosis of the disease as it appears in the North and the South (table 5). Whatever variations exist would necessarily demand a reconsideration of preventive and therapeutic schedules.

Table 2.—Rheumatic Heart Disease Prevalence: Southern Climates

Place	Report	Rate/1000
California (Redlands)	Sampson[4] (1945)	3.8
Southern Arizona	Paul[3] (1937)	5.0
Florida (Pensacola)	Packard[2] (1951)	3.8
Florida (Miami)	Saslaw[1] (1950)	5.0

Table 3.—Rheumatic Heart Disease Prevalence: Northern Versus Southern Climates

Climate	Range Rate /1000
Northern	16.3 - 45.0
Southern	3.8 - 5.0

Etiologic Factors

From the etiologic viewpoint, it is generally agreed that acute rheumatic fever occurs only following an infection with Group A beta hemolytic streptococci.[9,10] If this is so, how can the relatively lower incidence of rheumatic fever in Florida be explained?

Table 4.—Rheumatic Heart Disease Prevalence: Floridians Versus Non-Floridians (White Only)

Group	Floridians	Non-Floridians	Total
Total outpatients	625	1,028	1,653
Per cent rheumatic state	13.3	34.5	26.5
Per cent rheumatic heart disease only	2.9	15.4	10.7
Per cent congenital heart disease	33.0	17.7	23.5
Per cent no heart disease	53.7	47.8	50.0

First among the possible explanations (table 6) is that rheumatic fever is uncommon in Florida because Group A beta hemolytic streptococci are uncommon. According to Denny,[11] the incidence of streptococci in normal children is 5 to 10 per cent. During the period, February through May 1953, we recovered Group A beta hemolytic streptococci from the throats of 16.3 per cent of 343 healthy Miami school children, swabbed once each month during the study (table 7). Our streptococcal rate varied from 2.5 to 8.7 per cent per month, with an average of 5.1 per cent. We can conclude from these figures that the frequency with which Group A beta hemolytic streptococci were isolated in Miami, alone cannot account for the low rheumatic fever rate in this area.

Table 5.—Areas of Difference in Rheumatic Fever: Temperate Versus Subtropical Climates

1. Etiology
2. Manifestations
3. Diagnosis
4. Prevention
5. Treatment

The answer may lie in whether the organisms isolated are pathogenic or innocuous parasites. This distinction can be made only by immunologic studies, including antistreptolysin-O titer determinations, which are now in progress under the joint sponsorship of the National Children's Cardiac Hospital, the Dade County Health Department and the Florida State Board of Health. There is evidence, however, of the pathogenicity of the organisms recovered by us during February-May 1953. We found that of the 19 children from whom Group A, type 12 beta hemolytic streptococci were isolated, 13 had illnesses of the upper respiratory tract either in themselves or their immediate families, 3 had mumps, and 1 had "allergic" symptoms. Only 2 gave no history of illness.

Another observation in favor of the pathogenicity of our streptococcal strains is the increase in the number of typable strains from month to month. Such patterns generally are accompanied by a sharp rise in clinical infections.[12]

Now that we have seen that the low rheumatic fever rate in Miami cannot be explained by an absence of Group A beta hemolytic streptococci, let us consider the second possible explanation for the infrequency of the disease and its cardiac complications in this area. Do the streptococci prevalent in Miami have less power to produce rheumatic fever than these organisms elsewhere? That is, are they less "rheumatogenic" in the South than in the North?

Table 6.—Reasons for Low Incidence of Rheumatic Fever in Florida

1. Low incidence of Group A beta hemolytic streptococci
2. Streptococci have less power to produce rheumatic fever
3. Difficulties in diagnosis of rheumatic fever and low incidence of cardiac complications

Rammelkamp and Weaver,[13] in 1953, reported that "in general, approximately 3 per cent of streptococcal infections are followed by an attack of rheumatic fever." Earlier, Rammelkamp, Denny and Wanamaker[14] stated that "there is relatively little direct effect of altitude, climate, or humidity on the attack rate of rheumatic fever." Our antistreptolysin-O titer studies will help us to determine the number of actual streptococcal infections. This, in turn, will enable us to estimate the validity of this 3 per cent figure in our subtropical climate.

As a third possibility to explain our low rheumatic fever rate, we will now consider a remark which many of us have heard at one time or another: "You have rheumatic fever in your area, but you just do not recognize it." Every time I hear this it makes me bristle, and yet I must admit that there may be some real basis for this statement. It is conceivable that the entire pattern of rheumatic fever and rheumatic heart disease is so much milder here that cases may go unrecognized.

manifestations upon which we base our diagnoses are frequently absent. There remains carditis as the only major symptom of the disease. This major manifestation, in turn, usually makes itself known by the presence of a mitral systolic murmur and by nonspecific electrocardiographic changes, such as prolongation of the P-R and Q-T^c interval. The differentiation between such an organic murmur and one which is innocent poses a most troublesome diagnostic problem.

In southeast Florida, we have added difficulties in that subcutaneous nodules and erythema multiforme, the two minor manifestations most closely identified with rheumatic fever, are almost always absent. In 16 years of practice and close personal association with rheumatic patients in Miami, I have seen polyarthritis or subcutaneous nodules only in children who arrived from the North while their disease was still active. Of those children who experienced new episodes while residing in Florida, I have seen 2 with chorea and 1 with erythema multiforme.

Table 7.—Incidence of Beta Hemolytic Streptococci in 343 Miami School Children (February-May 1953)

Month	Number of Cultures	Group A Isolates		Cumulative New Isolates Only (Based on 288 Children)	
		Number	Per cent	Number	Per cent
February	279	7	2.5	7	2.5
March	308	12	3.9	8	5.1
April	281	16	5.7	11	9.0
May	286	25	8.7	21	16.3
Total	1,154	59	5.1		16.3

Problems of Diagnosis

This suggestion brings us to a discussion of the problems of diagnosis and the variations in manifestations of rheumatic fever in the South.

I have compiled in table 8 the major and minor manifestations of rheumatic fever. According to Jones,[15] we can feel safe in diagnosing rheumatic fever when two or more of the major manifestations are present. In warm climates, rheumatic fever is prone to occur without chorea or polyarthritis.[16] Thus, two of the three major

Table 8.—Manifestations of Rheumatic Fever

MAJOR

1. Migrating polyarthritis
2. Sydenham's chorea
3. Carditis

MINOR

Clinical

1. Fever
2. Abdominal pain
3. Erythema marginatum or multiforme
4. Precordial pain
5. Subcutaneous nodules
6. Purpura
7. Epistaxis
8. Pulmonary involvement
9. Muscle or joint pains
10. Anorexia
11. Easy fatigability
12. Retardation of growth

Laboratory

1 Electrocardiographic changes
   a. P-R prolongation
   b. Q-Tc prolongation
   c. Sinus tachycardia
   d. Other rhythm changes
2. Microcytic anemia
3. Leukocytosis
4. Increased sedimentation rate
5. Serologic abnormalities
   a. Elevated antistreptolysin-O titer
   b. Elevated antihyaluronidase titer
   c. Increased antistreptokinase
   d. Presence of C-reactive protein

In answering those who say that we do not recognize rheumatic fever, we must admit that many patients with undiagnosed fever may or may not be suffering from rheumatic fever. If in such cases the fever is to be considered rheumatic, we would have to modify extensively our present concepts of diagnosis of rheumatic fever, as set forth by Jones,[15] to solve our problem in the South. Such revision, however, does not seem to be warranted because of the low rate of rheumatic heart disease, which in turn probably reflects an actually low initial incidence of rheumatic fever in this area. Jones[15] emphasized that his criteria are to be used as a guide only and not as a substitute for sound clinical judgment.

The difficulty of evaluation of rheumatic activity prompted us to seek a simple method to help solve this perplexing problem. Dr. Streitfeld and I[17] recently reported a skin test for rheumatic activity in which we used the tetrahydrofurfuryl ester of nicotinic acid by inunction. We observed that normal children, those with congenital heart lesions and those with inactive rheumatic fever or rheumatic heart disease gave a typical reaction, consisting of erythema with or without edema, in over 97 per cent of 348 subjects. Conversely, 84 per cent of 38 patients with active rheumatic fever gave a nontypical response consisting of blanching or no color change at the site of application.

The tests were made in a number of institutions throughout the country without any prior knowledge of the rheumatic status of the patient. The clinician's estimate of activity was accepted without question, regardless of whether or not Jones's criteria had been fulfilled. Since there are sharp differences of opinion among physicians as to the evaluation of rheumatic activity, it is remarkable that so close a correlation was obtained between the type of skin response and the presence or absence of rheumatic activity. The very fact that there is so much variation in the evaluation of activity by physicians emphasizes the need for more adequate methods of estimating the status of rheumatic patients.

Therapy

Since we have shown that the rheumatic fever picture is different in Florida from elsewhere, it is logical to re-examine the prophylactic and therapeutic schedules currently in use.

The American Heart Association[18] recommends the daily administration of sulfonamides or penicillin for at least five years or until the age of 18 (whichever is later) to all persons who have had one or more attacks of rheumatic fever. It is believed that in this way streptococcal infections will be prevented, and thus also rheumatic attacks. In Miami, where the recurrence rate is low, we do not believe that it is necessary to keep all patients with rheumatic disease under 18 years of age on continuous prophylaxis. Such patients should be watched carefully and given the benefit of early and adequate antibiotic therapy in the event of infections of the upper part of the respiratory tract, dental attention, tonsillectomy, and so forth. This plan has proved satisfactory in our experience during the past five years.

The same principles of treatment — bed rest, nutritious food, favorable environment, salicylates, and general supportive measures — hold for the South as well as for the North. Usually, the period spent in bed is markedly less than that which might be expected in temperate areas; instead of in months, it is usually measured in weeks. Instead of large doses of aspirin, we have used only moderate doses (usually not over 60 grains daily) with success in all but a few cases. In these rare instances, we have resorted to cortisone or ACTH therapy with unimpressive results. When all signs of activity have subsided, the children are ambulated on a graduated scale.

Summary

It has been shown that rheumatic fever in a subtropical climate presents a different picture from that characteristically seen in more northerly areas. Not only is the disease clinically unlike its northern counterpart, but it is also milder, with fewer new attacks, fewer recurrences, and less severe cardiac complications.

In the attempt to explain the different behavior of rheumatic fever in a warm climate, studies thus far indicate that the low incidence cannot be explained by the absence of Group A beta hemolytic streptococci, since these organisms were recovered from the throats of 16.3 per cent of 343 normal Miami school children. This rate is similar to that previously reported elsewhere.

There are indications that the strains of streptococci isolated in the Miami area are pathogenic rather than harmlessly parasitic.

Immunologic studies of antistreptolysin-O titers now in progress will help determine the

actual number of streptococcal infections and thus provide a basis for the estimation of the incidence of rheumatic fever for comparison with similar northern statistics.

The low rheumatic fever rate in the South is probably due to the actual infrequency of the disease rather than to unrecognized forms, as some Northern investigators contend. The low incidence of rheumatic heart disease supports this belief.

A consideration of the major and minor manifestations of rheumatic fever indicates that the critical diagnostic features, as described in Jones's criteria, are generally absent here in the South. These criteria remain, nonetheless, an invaluable guide for accurate diagnosis.

The skin response to inunction with the tetrahydrofurfuryl ester of nicotinic acid may prove a useful aid in the diagnosis of rheumatic fever activity.

The differences in behavior of rheumatic fever and rheumatic heart disease in southern areas call for modified prophylaxis and treatment schedules. Routine daily use of sulfonamides or penicillin, as recommended by the American Heart Association, appears to be unnecessary, at least in Dade County, Florida, in view of the small number of new and recurrent attacks of rheumatic fever. Therapeutically, the same principles of management apply in the South as in the North, but in subtropical Miami, bed rest, dosage and duration of treatment have proved effective even when markedly reduced.

References

1. Saslaw, M. S.; Ross B. D., and Dobrin, M.: Incidence of Rheumatic Heart Disease in Native School Children of Dade County, Florida, Am. Heart J. 40:760-765 (Nov.) 1950.
2. Packard, J. M.; Graettinger, J. S., and Graybiel, A.: Incidence of Heart Disease in School Children of Pensacola, Florida, U. S. Naval Air Station, Pensacola, Florida, Project No. NM 001 057.02.01, October 25, 1951.
3. Paul, J. R., and Dixon, G. L.: Climate and Rheumatic Heart Disease; Survey Among American Indian School Children in Northern and Southern Localities, J. A. M. A. 108:2096-2100 (June 19) 1937.
4. Sampson, J. J.; Hahman, P. T.; Halverson, W. L., and Shearer, M. C.: Incidence of Heart Disease and Rheumatic Fever in School Children in 3 Climatically Different California Communities, Am. Heart J. 29:178-204 (Feb.) 1945.
5. Wedum, B. G.; Wedum, A. G., and Beaghler, A. L.: Prevalence of Rheumatic Heart Disease in Denver School Children, Am. J. Pub. Health 35:1271-1276 (Dec.) 1945.
6. Quinn, R. W., and Kincaid, C. K.: Rheumatic (Valvular) Heart Disease in Madison, Wisconsin: Survey of Seventh Grade School Children, Am. J. M. Sc. 223:487-494 (May) 1952.
7. Saslaw, M. S.: Ross, B. D., and Hernandez, F. A.: Rheumatic Heart Disease in Native-born Floridians and Non-Floridians, Am. Heart J. 47:580-586 (April) 1954.
8. Robinson, J. J., and Currens, J. H.: Preliminary Observations on Some Children with Rheumatic Heart Disease Transported to Subtropical Climate, J. Pediat. 28:426-428 (April) 1946.
9. Hauser, H. B., and Eckhardt, G. C.: Recent Developments in Prevention of Rheumatic Fever, Ann. Int. Med. 37:1035-1043 (Nov.) 1952.
10. McVay, L. V. Jr., and Sprunt, D. H.: Aureomycin in Prophylaxis of Rheumatic Fever, New England J. Med. 249: 387-393 (Sept. 3) 1953.
11. Denny, F. W. Jr.: Streptococcal Diseases of Childhood, Postgrad. Med. 13:153-156 (Feb.) 1953.
12. Rothbard, S., and Watson, R. F.: Variation Occurring in Group A Streptococci During Human Infection; Progressive Loss of M. Substance Correlated with Increasing Susceptibility to Bacteriostasis, J. Exper. Med. 87:521-533 (June) 1948.
13. Rammelkamp, C. H. Jr., and Weaver, R. S.: Acute Glomerulonephritis, Significance of Variations in Incidence of Disease, J. Clin. Investigation 32:345-358 (April) 1953.
14. Rammelkamp, C. H. Jr.; Denny, F. W., and Wanamaker, L. W.: Studies on the Epidemiology of Rheumatic Fever in the Armed Forces, in Rheumatic Fever, A Symposium, Thomas, L., editor, Minneapolis, University of Minnesota Press, 1952, p. 76.
15. Jones, T. D.: Diagnosis of Rheumatic Fever, J. A. M. A. 126:481-484 (Oct. 21) 1944.
16. Nomenclature and Criteria for Diagnosis of Diseases of the Heart and Blood Vessels, ed. 5, New York, New York Heart Association, 1953, p. 21.
17. Streitfeld, M. M., and Saslaw, M. S.: A Cutaneous Test for Rheumatic Activity in Children, Proc. Soc. Exper. Biol. & Med. 84:628-631 (Dec.) 1953.
18. Breese, B. B., and others: Prevention of Rheumatic Fever, Mod. Concepts Card. Dis. 22:158-161 (Jan.) 1953.

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Discussion

Dr. Sidney Grau, St. Petersburg: My appreciation and thanks go to Dr. Saslaw for the opportunity to discuss his paper. Reference was first made to Dr. Saslaw's work last year by Dr. Sidney Davidson of Lake Worth when he presented a paper to this society on the subject of "Southern Florida and the Cardiac Patient." Dr. Saslaw is making an attempt to prove on a scientific basis what we all feel empirically, namely, that rheumatic fever and rheumatic heart disease are less prevalent in the South. But the difficulties in diagnosis of first attacks in atypical cases of rheumatic fever and recurrences of rheumatic fever continue to plague us. More definitive methods of diagnosis are constantly being sought. Among these methods is the Trafuril inunction method just mentioned by Dr. Saslaw, which is still being investigated.

Recently, the specificity of the C-reactive protein determination in rheumatic activity was reasserted by Kroop and his associates from Brooklyn. This same group also studied the electrophoretic pattern in order to help determine the presence or absence of rheumatic fever. They stated that although electrophoresis is of no absolute value in determining rheumatic activity, the presence of an elevated beta globulin fraction should strongly suggest the diagnosis.

At the meeting of the American Heart Association recently held in Chicago, a paper was presented showing a close correlation between the incidence of abnormal ballistocardiograms and the severity of rheumatic activity. I submit for Dr. Saslaw's comment at the present time, and for future investigation if he deems it advisable, the possible use of the ballistocardiogram as an aid to diagnosis in these atypical cases of rheumatic fever or in recurrent cases of rheumatic fever.

I am a little reluctant to accept Dr. Saslaw's prophylactic treatment of rheumatic fever wherein he relaxes upon the recommendations of the American Heart Association. Even though the recurrence rate is low in the Miami area, statistics are of no value to the parents of a young rheumatic patient who has had an acute flare-up. As far as they are concerned, the recurrence rate is 100 per cent. Little effort and expense are involved in keeping a child on prophylactic oral penicillin. And who can tell? Maybe Dr. Saslaw's figure of 3.7 per cent recurrence rate would drop even lower with routine rather than selected antibiotic prophylaxis.

Dr. William P. Hixon, Pensacola: When Dr. Saslaw invited me to discuss his paper, he stated that he wanted an expression of the experience of physicians of various parts of Florida concerning this subject.

Pensacola is located approximately 6 degrees north of and about 3 degrees west of Miami. This difference in geographic location represents probably a greater difference in climatic conditions in part because of Miami's proximity to the Gulf Stream. The mean winter temperature in Pensacola over a period of 71 years is 54.3 F.

There is a somewhat greater concentration of the population here than in other parts of Florida, Pensacola ranking ninth in population and thirty-eighth in area.

The only carefully conducted statistical study of the rheumatic state that has been made in our community is a study by Drs. Packard, Graettinger, and Graybiel. This group reported, in October 1951, the results of a survey of the cardiovascular status of school children in Pensacola. This survey, therefore, represents chiefly the frequency of the cardiac complications of rheumatic fever. It is true that one would expect a correlation with the rate of rheumatic fever. We have no evidence, however, as Dr. Saslaw has pointed out, that this ratio is the same throughout the various sections of the United States. In the study by Dr. Packard and his associates, 2,600 school children were examined in three schools located in Pensacola, including the grammar school, junior high school, and high school grades. In this group, 10 cases of chronic rheumatic heart disease were found, representing 0.38 per cent of the total. In 8 of these cases, or 0.31 per cent, the child had acquired the disease while living in Pensacola. In addition, 15 cases were studied in which there was no clinical evidence of heart disease, but there was a well established history of one or more episodes of acute rheumatic fever, representing 0.57 per cent of the total number of children examined.

For those who are interested in a possible correlation between rheumatic heart disease and congenital heart disease as an index for comparison with other surveys, there were 10 cases of congenital heart disease reported. This number represented 0.38 per cent and equaled the number of cases of rheumatic heart disease. In 1953, in the records of the two major hospitals of our community, which receive about 90 per cent of all of the patients hospitalized, there were 21 cases of rheumatic heart disease. The total number of cases of active rheumatic fever reported was 3, and inactive 9.

These totals include no readmissions. I have made no attempt to evaluate this information on a percentage basis because no valid statistical results can be gleaned from them. It would appear, however, from a similar report in Dr. Saslaw's paper regarding the number of admissions in this category among the Miami hospitals, that the rates in Pensacola are reasonably close to the number reported by him in his paper. It would appear, from the information available, that rheumatic fever in Pensacola and this disease in Miami are similar.

While we recognize the fact that climate may be a major factor in its influence on the incidence of this disease in our geographic area, I am sure we all recognize the possibility that other factors, such as housing and general living conditions, probably exert some influence. It is generally accepted that the acute rheumatic state usually follows a hemolytic streptococcal infection. In susceptible individuals, however, the rheumatic state has also been shown to occur as a result of a nonspecific sensitivity to such stimuli as trauma, exposure to cold and excessive fatigue, in addition to the other types of infections.

Dr. Graettinger, in a review of the occurrence of epidemic rheumatic fever in the United States Navy during World War II, reported that climate was a factor of only minimal importance. Although it is a matter of conjecture, it would appear from the information available that rheumatic fever occurs in a more attenuated form and with fewer complications in the areas which enjoy a milder climate and where living conditions are less crowded.

If this is true, Dr. Saslaw's study becomes of great importance to us all and points up the need for simpler methods of diagnosis in these attenuated cases if we expect to make any reasonable progress toward better control of this disease and its complications in the areas enjoying the milder climates.

DR. SASLAW, concluding: I should like to thank the discussants for their excellent remarks. In regard to Dr. Grau's statement about C-reactive protein, this is a nonspecific test and has been a difficult one to perform because it has been difficult to prepare the protein. Now that it is commercially available, the test will be much simpler to perform, but it is a test that has to be followed along and one has to draw blood repeatedly from the children at periodic intervals to see which way the C-reactive protein results are going. As far as electrophoresis and studies of the beta globulins by Dr. Kroop are concerned, these too are blood tests and, as with all blood tests, are difficult to perform on children. They are only important, not as single tests, but in the changing titers over a period of time. Our skin response is a simple procedure which requires rubbing a little ointment on the skin and observing in a half hour. We think it is much easier, at least as a guide.

As to prophylaxis, we cannot give a final answer and we would hesitate at this time to be in violent disagreement with Dr. Grau. In our experience, however, we find exceedingly few rheumatic recurrences. We quoted a figure of 3.7 per cent in 272 known rheumatic cases. Actually, when one employs the Jones criteria, this figure is considerably less. Furthermore, while it is true that if rheumatic fever develops in 1 case, that is 100 per cent to the parents of the child, so is it also true that if a penicillin or sulfa drug sensitivity response develops in a child (and in some instances such a response has terminated fatally), that also would be 100 per cent in the opinion of the parents.

As to Dr. Hixon's comments, we are quite familiar with the work of Drs. Packard, Graettinger and Graybiel, and the figures they obtained were certainly similar to ours. There was one difference in the two technics of study. Dr. Graybiel and his group limited their study to white children only. Ours were about half and half white and Negro, and it was interesting that in our study all 5 cases of rheumatic heart disease that we encountered were in Negroes. We encountered none in white children. We also found a 6 per thousand incidence of congenital heart disease, which means that rheumatic and congenital heart disease split the field in children.

As to the effect of geography, we must realize this fact, that where the temperature is warm, where there is an average temperature of 70 or 75 F., the children will be out in the open throughout the greater part of the year, and the opportunities for contact and close quarters are minimized. The ultimate beneficial effect may be due to avoidance of crowding, so prevalent in northern communities where, because of the poor climate children are forced to stay indoors for months at a time. We are working now on some necropsy studies in the Miami area and we would say that the incidence of rheumatic heart disease in autopsy cases will be exceedingly low, to further our contention that rheumatic fever and its complication of heart disease occur infrequently.

CLINICAL SESSION

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Solitary Discrete Pulmonary Densities

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As experience with the newer problems in medicine and surgery accumulates, it frequently is possible after a time to analyze one's own experience as well as the collective experience of others interested in a given problem and to reach fairly definite conclusions about how that particular problem may be handled most successfully. The experience with solitary discrete lesions of the lung that has accumulated in the past decade now will permit one to apply this principle and to propose a definite plan of management.

The purposes of this paper are to discuss the nature of solitary discrete pulmonary densities, to review the various diagnostic procedures available for the evaluation of these lesions, and to outline a plan for the proper management of patients who present themselves with such conditions.

The magnitude of the problem is exemplified by the finding of from one to two possible tumors of the lung in each 1,000 persons examined in mass roentgen surveys. With the increasingly widespread use of roentgenograms of the chest, one may expect an ever increasing number of such lesions to be detected.

Various terms have been applied to these pulmonary densities, such as coin lesions, peripheral nodules, and solitary, circumscribed tumors. Arbitrary classifications based on the size of the lesion, the presence or absence of symptoms, and the location within the lung have been advanced; however, these "pigeon-holings" seem to serve little if any useful practical purpose, and it would seem more valuable to study the group as a whole.

Diagnosis

A correct preoperative diagnosis (table 1) is of utmost importance, but is, unfortunately, impossible to obtain in the vast majority of instances. A careful and complete history must be obtained, and a thorough physical examination must be performed. In general, patients with tumors, benign or malignant, are just as likely to be asymptomatic as those with other lesions. The statistical difference is so slight that it is of no help with the individual patient. Physical examination of the chest almost always gives results within normal limits; however, the remainder of the examination may disclose a previously unsuspected mass in the breast, abdomen or prostate.

Complete blood studies have proved to be of little value in the differential diagnosis with the possible exception of the sedimentation rate, which has been shown more frequently to be elevated in those patients with malignant neoplastic disease.

Table 1.—Procedures for Diagnostic Study

I	History and physical examination
II	Routine blood studies
III	Roentgen examination of chest and gastrointestinal and genitourinary tracts
IV	Skin tests
V	Sputum studies, bacteriologic and cytologic
VI	Bronchoscopic examination

Roentgen examination should be thorough and comprehensive in every patient and should include posteroanterior stereoscopic views, lateral views, and planigrams of the chest when indicated. Bronchograms ordinarily are of little or no value. Previous roentgenograms of the chest, if available, may give invaluable information; however, it should be noted in this regard that there is increasing evidence that the roentgen ray shadow of malignant neoplasms may not change for years, and the finding of an unchanged lesion in a series of roentgenograms taken over a period of several years does not necessarily justify a complacent attitude. Conversely, benign lesions may increase in size, so that enlargement of the

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shadow is not always conclusive evidence of malignant disease. The one additional roentgen finding in the lung of importance is the presence or absence of calcification. With rare exceptions, calcification is indicative of a tuberculoma or a hamartoma. One should keep in mind the occasional coincidental development of a malignant neoplasm in an area where calcification has been present previously. A roentgen survey of the gastrointestinal and genitourinary tracts may disclose a "silent" primary tumor.

Skin tests for tuberculosis, coccidiodomycosis, and blastomycosis have been performed in a great many cases and found to be more confusing than enlightening. A tuberculin test giving negative results would be thought to be suggestive of a neoplasm, but, in a large reported series, the percentage of tuberculin tests giving negative results was the same for the granulomas as for the primary bronchogenic carcinomas.

Bacteriologic examination of the sputum rarely gives information of value because of the relative inactivity and encapsulation of the tuberculous lesions encountered in this group of patients. Cytologic examination of the sputum is much more likely to be helpful and should not be omitted in any patient. Bronchial washings and smears obtained during a bronchoscopic examination are even more reliable and may make the preoperative diagnosis definitely correct. It should be emphasized that a cytologic study giving negative results by no means rules out the possibility of malignant disease since malignant cells are found in the sputum of only about 50 per cent of patients later proved to have a malignant tumor.

One would not expect to be able to visualize the majority of these tumors with the bronchoscope because of their peripheral location, and such has proved to be the case. The chief value of bronchoscopy lies in its use for obtaining material for cytologic examination. It recently has been advocated by some that bronchoscopy be omitted entirely or be performed only immediately prior to thoracotomy since so little information has been obtained by its use.

Malignant Lesions

A number of well documented series of cases of solitary discrete pulmonary densities have been reported in the literature during the last five years (table 2). Most of these reports contained an appraisal of the percentage of malignant tumors as opposed to the percentage of benign lesions encountered in those patients upon whom operation was performed and a definite pathologic diagnosis established. The percentage of malignant growths varied from 15 to 42.8 per cent. In addition, the authors were unanimous in stressing their inability to arrive at a correct preoperative diagnosis. Using all the diagnostic methods at their disposal, they found that a correct preoperative diagnosis was determined in only about 50 per cent of the cases.

Table 2.—Malignant Lesions in Reported Series

	Number of Cases	Percentage Malignant
Mayo Clinic	156	35.3
Walter Reed	24	15.0
Sharp and Kinsella	55	27.3
Overholt	162	35.8
Abeles and Ehrlich	21	42.8

A typical example of the various types of lesions encountered in a large series and their relative frequency is presented in table 3. In general, malignant tumors and tuberculomas were the two most common lesions found in most series, and the relative incidence of each was about the same.

Table 3.—Pathologic Diagnosis Mayo Clinic, 156 Cases

	Percentage
Malignant neoplasms	35.3
Benign neoplasms	19.1
Inflammatory	42.9
Miscellaneous	2.6

Tuberculoma

Much confusion exists about the nature and significance of tuberculomas (table 4), and a brief discussion of these lesions would seem to be appropriate. Tuberculoma is a term loosely applied to discrete tuberculous lesions. They may develop from the blocking of a cavity, encapsulation of a reinfection focus, or encapsulation of a giant primary focus. It is not possible to determine the activity of the tuberculous process by roentgen examination alone. On pathologic examination, these lesions may vary from a dense, concentrically calcified mass in which no tubercle bacilli may be found to a soft, caseous mass from which acid-fast organisms may be demonstrated readily on smear or culture. It likewise is impos-

sible to predict the future behavior of any given lesion. The potential danger of spread or extension of the disease is a real one, and most thoracic surgeons agree that resection of tuberculomas is the procedure of choice even when the diagnosis can be absolutely established.

Table 4.—Dangers of Tuberculomas

I	Local reactivation may occur
II	Rupture into bronchus with bronchogenic spread
III	Medical or collapse therapy ineffective
IV	Cannot be differentiated from carcinoma

Treatment

It is difficult to understand, in view of the advanced state of the present knowledge about solitary discrete pulmonary densities, why the concept of early exploration and resection has not met with universal acceptance. Removal of tumors of the breast and thyroid gland as soon as they are discovered is an established treatment, and no one advocates watchful waiting to see what will happen. A study of the comparative percentage of malignant disease in the three types of lesions reveals that the pulmonary nodule is four times more likely to be malignant than an apparently benign nodule in the breast or thyroid gland (table 5).

Several typical examples are presented.

Table 5.—Comparative Percentage of Malignant Disease

Clinically benign nodular goiter	7.6
Clinically benign breast lesions	6.7
Solitary pulmonary nodules	29.2

Report of Cases

Case 1.—A 50 year old white man was admitted to the hospital with a history of cough and discomfort in the left side of the chest for three months, but no hemoptysis. Roentgen examination revealed a 5 cm. rounded density in the lower lobe of the left lung. Bronchoscopy, sputum examinations and roentgen examination of the gastrointestinal and genitourinary tracts revealed no abnormalities. A lobectomy was performed, and the postoperative course was uncomplicated. The final diagnosis was squamous cell carcinoma.

Case 2.—A 38 year old white man had been examined at a sanatorium for a solitary lesion in the lower lobe of the right lung, which had not been demonstrated on a roentgenogram made nine years earlier. Sputum examinations, skin tests and bronchoscopic examination gave negative results. Roentgenograms showed an area of increased density behind the anterior end of the right sixth rib with questionable calcification. At operation, a firm 2 cm. mass was encountered in the lower lobe of the right lung with atelectasis of the medial basal segment. A lobectomy was performed, and the final diagnosis was bronchogenic cyst.

Case 3.—A 46 year old white man was admitted to the hospital for removal of a stone from Wharton's duct. A routine roentgenogram of the chest revealed a 3 cm. sharply defined density in the central portion of the upper lobe of the right lung opposite the fifth interspace posteriorly. The reaction to the tuberculin test was strongly positive. The remainder of the laboratory studies gave negative results. A lobectomy was performed. The final diagnosis was primary bronchogenic carcinoma.

Case 4.—A 37 year old white man was admitted to the hospital for investigation of an asymptomatic lesion which had been discovered on a chest survey film three weeks previously. The reaction to the tuberculin test was positive. Bronchoscopic examination revealed no abnormalities. Roentgenograms revealed a 2 cm. mass in the right lung at the second interspace anteriorly. At operation, a single mass was found and a wedge resection performed. The final diagnosis was tuberculoma.

Case 5.—This case does not meet the criterion of having a solitary density, but is presented because it exemplifies well the difficulties encountered in dealing with these problems. A 50 year old white woman consulted her physician because of a vague discomfort in the upper portion of the left side of the chest. She had no other symptoms. A roentgenogram revealed a calcified lesion in the upper lobe of the right lung and a smaller mass in the upper lobe of the left lung. She was treated with streptomycin for three weeks, and roentgen examination then showed that the lesion in the upper lobe of the left lung had increased in size. Skin tests and bronchoscopic examination gave negative results. A pneumonectomy on the left side was performed. The final diagnosis was bronchogenic carcinoma with metastases to the hilar lymph nodes.

Conclusion

It may be concluded, therefore, that a simplified plan of preoperative diagnostic study should be adopted. The history, physical examination, roentgenograms of the chest and sputum studies should be obtained, but there must be no delay while one waits for cultures of the sputum or the needless repetition of tests giving negative results. The only accurate method of arriving at a correct diagnosis is tissue biopsy and immediate histopathologic examination. Exploratory thoracotomy is recommended without hesitation for every solitary discrete pulmonary density unless the diagnosis of a malignant neoplasm can be definitely excluded.

111 Broadway.

Discussion

Dr. Ashbel C. Williams, Jacksonville: Dr. McSwain is to be complimented on a most excellent presentation of a timely subject. Few conditions in medicine have aroused as much interest or assumed as much importance in such a short period of time as has cancer of the lung. According to Overholt, the incidence of cancer of the lung has increased 1,500 per cent in the last 25 years. It continues to rise at the same rate. DeBakey stated that this disease constitutes 10 to 15 per cent of all cancer. These facts explain why the American Cancer Society has made cancer of the lung its top target for the present year.

How have these cases of cancer been handled in the past? I think one of the papers you have just heard

answers that. The record is dismal. In a series of 721 patients at the Overholt Thoracic Clinic, only 9 per cent were found to have cancer limited to the lung. Parker reported from Charleston that of 66 cases of cancer of the lung, he found only 3 cases with the disease limited to the lung, 3 of 66 with a chance of cure. A large part of this failure is because in most of these patients the disease was not diagnosed or treated until they had symptoms, until in other words, they had incurable disease.

How can these results be improved? By diagnosing and resecting such lesions when they are silent and have not gone to the point of causing symptoms. Improvement can only be attained by the widespread use of roentgenograms of the chest, as you have already heard. It is specifically recommended that all persons over 40 years of age have a roentgen examination of the chest each year and that those over 40 years who smoke and especially those who smoke heavily should have one every six months. How can this objective be obtained? (1) By making such an examination a routine part of every physical check-up. (2) By encouraging hospitals to make this examination a part of routine admission studies. (3) By cooperating with the mass chest x-ray program of the Florida State Board of Health and the Florida Tuberculosis and Health Association. (4) By urging radiologists to offer a single scout film of the chest at a reasonable charge so that physicians will feel no hesitancy in referring patients.

How much improvement can be expected from such a program? According to Overholt, lesions as small as 3 mm. in diameter can be seen by roentgen ray. He reported a resectability rate of 79 per cent in 1952 in silent lesions found in a mass survey in Massachusetts. In 70 per cent of these silent cases the cancer had not extended beyond the lung at the time of operation. These results have been duplicated by others, namely, Guiss in California, and there are others, too. Five year survival rates of 30 to 40 per cent in such cases have already been reported. This contrasts with the 5 per cent obtained under the old regime. We now have the means of cure in 1 out of 3 instead of 1 out of 20 patients.

The American Cancer Society is in the midst of a vast public education program to get persons to the doctor in time and to create a public desire for annual chest x-ray studies. Dr. Sharp of the Florida State Board of Health tells me that in 1953 the mass chest x-ray survey in Florida brought to light a little over 2 cases per thousand where tumor was suspected. The rate of suspicious tumor findings would be much higher per thousand in persons over 40 years of age — amongst men over 40 years of age and especially amongst men over 40 who are heavy smokers. It is perhaps not out of place to remind those of us who are not radiologists but who examine chests either by x-ray or fluoroscopy that we assume a grave responsibility which must be discharged with the utmost caution and deliberation. The recognition of the first signs of cancer of the lung in the roentgenogram is a meticulous problem calling for a high degree of experience and skill. As physicians we should help to shore up this program of early diagnosis and treatment of cancer of the lung in every detail.

In closing, I should like to say that the program of the Cancer Committee of the Florida Medical Association, and also that of the Florida Cancer Council, is stressing the use of the mass x-ray survey in the diagnosing of early cases of silent cancer of the lung above everything else, and I hope that we will be able to create the demand to have these films so that we can help to change this picture.

DR. FREDERICK K. HERPEL, West Palm Beach: Mr. Chairman, I hesitate to say anything about this subject because I realize that with the implied criticisms that have been made here today, we as radiologists must take our part. We unfortunately are dependent to a great extent in getting across what we are trying to say about examinations on the cooperation of the individual physician who refers the patient. We are actually acting in the status of physicians who are examining referred patients. That of course does not eliminate our responsibility for questioning the patient or trying to find out as much as we can about the patient at the time we examine him. I am certain that I have erred in the past, perhaps in the immediate past, in not stressing sufficiently to physicians the importance of follow-up — and that means the immediate follow-up — procedures which should be used in every suspicious lesion of the chest. I have seen, I am certain, a number of cases in which I should have been much more positive than I was in making recommendations to the examining physician. Those of us who are practicing radiology hesitate to be too verbose and too elaborate in our impressions and our reports. I do not know how we can get away from that attitude. We try to do as good a job as is possible in accurately describing what we see.

Actually, we are dealing with deviations from the normal densities and as such, I believe that all these should be meticulously recorded. I am not in agreement and have never been in agreement with the principle that the radiologist is supposed to make a diagnosis in every case and tell the doctor exactly what is wrong. I think that physicians should be sufficiently interested in their patients to follow up deviations from the normal which are reported. Now perhaps I have been wrong in not being more positive. I am perfectly willing to take a position on any case and say that I believe that this patient should be most carefully followed up and that everything should be done that possibly can be done to make an accurate diagnosis. In many instances that is not possible and it is not done.

One of the speakers this afternoon stressed the importance of conferences between the referring physician, the chest consultant and the radiologist. I am certain such conferences are not being held as often as they should be. There is nothing that I would welcome more in the practice of radiology than the opportunity to sit down and talk with the individual physician, who may be a general practitioner, and with the specialist in diseases of the chest — to sit down and have a little round table discussion, discuss the films and lay the cards on the table all the way around. We can learn from every clinician. If we cease to learn from the clinician, we cease to grow mentally, and it is necessary for us to grow mentally at a pretty rapid pace because the problems of radiology are increasing just as rapidly as the problems in every other specialty.

I have been greatly impressed with the quality of these presentations. I am also of the opinion that the time is here and has been here for some time when it is not necessary for Floridians to go beyond the line between Georgia and Florida to obtain what I would call as nearly perfect medical and surgical care as it is possible to obtain. It is delightful to me over 27 years of going to these meetings to see the increasing quality of the presentations, to see the growth in surgical and medical stature of the men who are practicing here, and to know that we are each year acquiring more and more men who are highly competent to carry out the functions of a medical profession. I think we are beginning to measure up very significantly to the stature that is demanded of us. I wish to congratulate the program committee, of which I was merely an incidental part this year, and also all of the participants in this program who have given us a most interesting session.

Case of Serious Florida Diamondback Rattlesnake (Crotalus Adamanteus) Bite

Harry F. Watt, M.D.
Ocala
and
C. B. Pollard, Ph.D.*
Gainesville

Although the incidence of poisonous snake bite is not high, each case is a potentially serious one. The seriousness is dependent upon a number of factors: the kind of snake, the amount of venom injected into the victim, the toxicity of the venom (the venom from two snakes of the same species of comparable size may vary considerably in toxicity), the location of the strike on the body, and the weight of the victim. Since some of these factors cannot be determined, each case warrants prompt first aid, medical treatment and observation.

Of the four poisonous snakes in Florida, the coral snake produces the most toxic venom per unit of weight. The most feared, however, is the Florida diamondback rattlesnake. This snake is capable of injecting a large quantity of venom as it has long fangs and can strike with tremendous force. Contrary to general belief, it does not always give a warning rattle before striking.

Probably because of the wide geographic distribution of the comparatively few cases of poisonous snake bite in this country, little research has been done in the field of treatment. Details of relatively few cases have been published, and most of these have not dealt with the Florida diamondback, which must be recognized as one of the two most deadly rattlers in this country. No less than 26 kinds of rattlesnakes inhabit the United States. With the increase in population of Florida the number of snake bite cases appears to increase, although complete records are difficult to obtain and no records have been available until recent years. Andrews and Pollard[1] were the first to report appreciable data on cases in the state in which the patient was hospitalized.

In view of the opinions which are without scientific foundation and the variety of treatments which has been employed, it is considered desirable to report serious cases in detail.

The case of Florida diamondback rattlesnake bite reported here presented several interesting and unusual aspects. The patient, a large and muscular man, had been the victim of nine previous bites of poisonous snakes. Three of these involved the Florida diamondback rattler and were serious, although less serious than in this instance. The 6 foot rattler struck above Gokey snake-proof boots and buried one fang in the soft tissue inside the right knee. The snake was unable to withdraw the fang and was pulled loose by the victim. The fang mark was cruxated immediately. A tourniquet was placed above the bite, and suction was applied to the cruxated wound. In 15 minutes after being bitten the patient was unable to walk without assistance; in 35 minutes he was admitted to Munroe Memorial Hospital in Ocala by stretcher. By that time he was experiencing a tingling of the hands, chest and face and a numbness of the upper lip.

Patient Describes Experience

The sensations experienced by the patient are described in his own words:

"This was my worst snake bite. I was tired when it happened — too tired after a long hard summer season. There were more snakes to be milked, but I decided to take a little nap in the laboratory. Instead of sleeping, however, I got an idea about a new way to milk cobras; so thus inspired, I put on my snake-proof boots and went into the milking pen. I milked two or three cobras as an experiment, found that the new

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method worked, and then proceeded to put all the cobras — 60 of them — in the pen where I could reach them for individual milking. While moving around in the back part of the milking pen, I noticed an eastern diamondback rattlesnake that was badly frightened and belligerent. I therefore pushed him into the corner with my snake hook.

"A minute later I was having trouble getting a cobra off the snake hook and did not see this pugnacious 6 foot rattlesnake sneaking up on me. The first thing I knew, I heard and felt the snake's fang in my leg above the boot. Momentarily he was stuck there, and I knocked him free with the snake hook. It was hard to believe the snake had come from a distance of 7 feet to attack me and had struck more than half his length at a 45 degree angle to a height of 22 inches. I pushed the rattlesnake clear across the pen and opened the door to the laboratory. I had trouble closing the door because a cobra got in the way; so I had to lift him up with the snake hook and put him back through the door before closing it. I examined the bite. I found one deep fang puncture, but there was no pain or other symptoms at this 30 second period. Nevertheless, I made a deep cut with my lance and started suction with the vacuum kit.

"This was my tenth snake bite. Some bites had been mild, and three serious. From these experiences I had believed that the seriousness of a snake bite could be determined by sudden pain and the amount of swelling. But this time I was to learn differently. After two minutes had elapsed and there was no pain, only a slight numb feeling, I began to think that I had escaped with another mild bite, but at the end of approximately five minutes my facial muscles began to twitch. So I phoned my wife to come and take me to the hospital. I called my associates to help apply more suction, tie a tourniquet and make additional cuts. Approximately four minutes later it was difficult to talk plainly, and it was hard to walk to the car just outside the laboratory building. Other muscles were beginning to twitch rapidly. Still there was no pain.

"By the time I had reached the hospital I was so paralyzed that I could not walk at all, or even move my feet. It was apparent to me now that I had received so much venom that it had numbed the nerves; therefore, the lack of pain. The neurotoxic factor in the diamondback rattlesnake venom was causing my flesh to jump and twitch with the same feeling as of electricity charging through. The muscle twitching became steadily worse, and it was the most uncomfortable experience I have ever had with snake bite, but was compensated by the lack of pain. I was worked on for over an hour in the emergency room before being transferred to a room. I can recall only vaguely what happened the next six days; however, I do recall that at various times everything appeared to be yellow. When my mind became clear, I complained about the ice packs. The packs were removed. The pain soon became in-

Table 1.—Blood and Transfusion Data in Case of Serious Rattlesnake (Crotalus Adamanteus) Bite

	Hospital Day								
	1	2	3	4	6	8	11	16	20
Red blood cell count (millions per cu. mm.)	4.7	5.3	4.7	4.2	3.7	4.0	4.3	4.6	4.6
Hemoglobin (grams per cent)	15.4	16.4	14.1	12.7	11.5	12.1	13.2	13.8	13.3
White blood cell count (thousands per cu. mm.)	9.8		21.5						13.5
Whole blood transfusions, 500 cc. each (number)	1	1		1	1				
Blood pressure	110/70	90/78 92/74	120/96	126/86 134/68	98/54	128/80 106/62			130/70

tense, and I requested replacement of the ice packs on my leg. The muscle twitching continued for several days, and I remember thinking when it finally stopped that I was just as tired as if I had run a hundred miles. What went on and was done for my physical condition is a matter of hospital record. I certainly cannot remember it accurately. I know that when I could finally raise my head and look at my leg, it was swollen and black, and I could not move it. When recovery warranted attempting to move the leg, extending it downward while trying to stand was so painful that I could not stand the pain over half a minute.

"After 22 days in the hospital and 102 more days of gradual recovery at home, a total of four months, I was able to go back to the Reptile Institute for a partial day's work.

"In this case I learned that immediate pain does not always result from the bite of a Florida diamondback rattler. This case also illustrates the value of research. Undoubtedly I survived only because I had available the best of modern scientific treatment. I cannot help feeling a great deal of satisfaction at having survived a most serious, often fatal type of snake bite; but brother, I don't want any more!"

Record of Case

This 43 year old white man was admitted to the hospital about 35 minutes after the snake bite. He was unable to walk and complained of tingling of the hands and face, particularly around the lips. His speech was affected; he was weak and nervous. Physical examination showed the heart to be normal in position and size with no murmurs; the lungs were clear; the liver and spleen were not palpable. The blood pressure was 100 systolic and 70 diastolic. The inner surface of the right leg at the knee showed a dark area about 1 inch in diameter. This immediate area around the fang puncture was excised, and the patient was given five ampules of Antivenin. He was then given a transfusion of 500 cc. of whole blood. Suction cups were used intermittently for about 10 hours on small incisions surrounding the fang puncture. Three hours after the accident the patient was complaining of intense pain in the right leg and chest.

In accordance with the recommendation of Andrews and Pollard,[1] the right leg, ankle to groin, was kept in ice packs for eight days.

Twenty hours after the victim was struck by the snake his right leg, calf to groin, was badly swollen and almost completely black. The swelling started to decrease on the fifth day. By the eleventh day swelling and cyanosis were only slight.

During the period from the second day to the sixth day in the hospital the icterus index fluctuated between 6.8 and 11.2. The highest value was shown on the third day.



Fig. 1.—Note absence of tissue necrosis at the site of the bite.

On the second day the patient complained of an intense itching of the back and arms. This condition was completely relieved and controlled by 25 mg. of Benadryl three times a day.

Penicillin, 400,000 units, and combined tetanus-gas gangrene antitoxin, 3,000 units, were administered the first day. The penicillin dose was repeated the second day. Infusions of 1,000 cc. of 5 per cent glucose were given on the first and

second days. Whole blood transfusions, 500 cc. each, were given on the first, second, fourth, and sixth days. One vial of Combiotic was given on each of the fifth, sixth, seventh and eighth days. Frequent doses of Demerol were required for pain. The position of the patient was changed every few hours.

The daily temperature ranged from 97 to 103 F. during the 22 days of hospitalization. The lowest temperature was on the third day, while the highest range occurred from the fifth day through the eighth day. During the last four days in the hospital the temperature was normal. The pulse rate varied from 72 to 115. Except for high albumin, urine specimens were practically normal.

Blood data are shown in table 1.

Particularly noteworthy in this case is the absence of tissue necrosis at the site of the bite (fig. 1).

When the patient was discharged from the hospital on the twenty-second day, a slight edema of the right ankle and pain in the calf of the leg persisted. He was able to walk a few steps, with difficulty. Numbness and tingling of the upper lip, which developed in a few minutes after the snake bite, were still sensed by the patient when discharged. He was confined to his home for a period of 102 days before he was able to return to work for part time duty.

Treatment Recommended

The treatment we recommend consists of the following:

1. Application of a tourniquet and ice packs; incision of fang marks, suction and physical inactivity in all cases of poisonous snake bite.
2. In serious cases of Florida diamondback rattlesnake bites these first aid measures should be followed by:
   (1) Prompt administration of Antivenin (minimum of five ampules).
   (2) Whole blood transfusions in the early stages of treatment.
   (3) Continuation of ice packs and transfusions as indicated.

References

1. Andrews, E. H., and Pollard, C. B.: Report of Snake Bites in Florida and Treatment: Venoms and Antivenoms, J. Florida M. A. 40:383-397 (Dec.) 1953.

P.O. Box 146.

Problems in Poliomyelitis

LORENZO L. PARKS, M.D.
JACKSONVILLE

There are two problems that almost every health officer has had to deal with if he has been long in Public Health. These two problems seem to cause more people greater concern than almost any public health problem of which I can think. Many people seem to lose all reasoning power and accept the free advice of everyone. The rumors spread and grow like a snowball rolling down a hillside. I refer to the poliomyelitis and rabies problems. No attempt will be made to discuss the rabies problem in this paper. I believe that when a poliomyelitis case occurs in a community, many people experience the feelings that our forefathers had years ago during epidemics of smallpox, yellow fever and other severe diseases. It is the fear of the unknown that seems to trouble us most, and that is about where we find ourselves today in the control of poliomyelitis.

When I accepted a place on this program I was thinking only of the poliomyelitis problems that the health administrator has to face. In reviewing literature for ideas for this paper I have found so many references, volumes of literature, so many different ideas and so little that has been proved that I decided poliomyelitis could be discussed from any angle and no one could prove that my comments were incorrect. During the nine years of the existence of the Florida Health

Read before the Florida Health Officers' Society, Ninth Annual Meeting, Hollywood, April 25, 1954.

Officers' Society, I find that poliomyelitis has been the subject of a paper for our annual program four times. Now, I am trying to discuss it this year. I assure you that I will not add any new ideas either.

I do not mean to imply that we know nothing about this disease. The pathologic findings, symptoms, various types, complications and many other facts are known by you and are readily available in the textbooks. On the other hand, we know little about how it is spread, the incubation period and other information essential to control the disease as we do in typhoid fever, smallpox or diphtheria.

One writer says that we may take tonsils out if poliomyelitis cases are occurring in the community; another says it is dangerous and may cause poliomyelitis of the bulbar type to develop in cases in which the patient has had a recent tonsillectomy. Some claim that if the tonsils have ever been removed, their absence predisposes to the bulbar type of poliomyelitis. Other samples of the state of confusion that we have found ourselves in from time to time are as follows:

You recall two years ago the advisability of giving inoculations was questioned and there was a threat to stop all inoculations if poliomyelitis cases occurred in the community. This idea has practically died out, too, except in epidemic areas. You remember the many dollars wasted on spraying cities by airplanes to control this disease, and yet some of these same cities allowed garbage to collect for flies to breed in. One year ago it was decided that gamma globulin was of value in preventing poliomyelitis. Gamma globulin was provided by the National Foundation for Infantile Paralysis and the Red Cross through the State Board of Health for the prevention of poliomyelitis. I decided recently to review the literature to see what convalescent serum or gamma globulin was good for, and I find it has been used for many diseases in the past. It appears that today we think that gamma globulin is of value in the control of measles (rubeola), infectious hepatitis and agammaglobulinemia, and is of questionable value in poliomyelitis. You know the status of gamma globulin today for the prevention of poliomyelitis; we cannot say it is of value and cannot say that it is not. Mumps convalescent serum may be of value in the prevention of mumps.

Handling Gamma Globulin

I need not tell you of the many problems that have come to us in the handling of gamma globulin during the past year, because you, too, have shared in this experience. We have had worthy requests for gamma globulin from all of Florida and from Cuba and Costa Rica. We have tried to comply with the regulations set up for the distribution of this biological. The part that practicing physicians have played in the handling of gamma globulin should be commented upon. We have been informed by many practicing physicians that they wanted us to set up regulations for the distribution of gamma globulin since it is not available on the market. They wanted us to stick by the regulations because it made their task easier in meeting the requests and demands of their patients. On the other hand, some physicians much prefer to get their biologicals at the drug store and not from the state. We have been alert to the possible problem of black market in the gamma globulin distribution by the state, but I am happy to report that this has not been a problem, or it has not been brought to our attention if it has occurred.

It has been recommended that gamma globulin now be used only for group inoculations in groups larger than the single family. We expect to have more gamma globulin available to us this year than last year. We plan to continue to make gamma globulin available to direct contacts and neighborhood contacts as prescribed by the attending physician as long as gamma globulin is made available to us. The dosage perhaps should be increased to an average of 10 cc. per case rather than an average of 7 cc., which has been used.

We have tried to analyze the cases of poliomyelitis that have been reported to our office. It is noted that there has been a definite shift in pattern to cases occurring in the older ages. One would expect more cases in the younger group since there has been an increase in the population in the younger children. The increase in the cases among the older age group appears to be significant, based upon the cases reported during the years from 1946 through 1953.

Our experience in Florida, as you know, is that polio occurs in every month of the year; however, the peak months are between August and October.

New Vaccine

During the last three months we have devoted considerable time to collecting data, as well as to

second days. Whole blood transfusions, 500 cc. each, were given on the first, second, fourth, and sixth days. One vial of Combiotic was given on each of the fifth, sixth, seventh and eighth days. Frequent doses of Demerol were required for pain. The position of the patient was changed every few hours.

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Officers' Society, I find that poliomyelitis has been the subject of a paper for our annual program four times. Now, I am trying to discuss it this year. I assure you that I will not add any new ideas either.

I do not mean to imply that we know nothing about this disease. The pathologic findings, symptoms, various types, complications and many other facts are known by you and are readily available in the textbooks. On the other hand, we know little about how it is spread, the incubation period and other information essential to control the disease as we do in typhoid fever, smallpox or diphtheria.

One writer says that we may take tonsils out if poliomyelitis cases are occurring in the community; another says it is dangerous and may cause poliomyelitis of the bulbar type to develop in cases in which the patient has had a recent tonsillectomy. Some claim that if the tonsils have ever been removed, their absence predisposes to the bulbar type of poliomyelitis. Other samples of the state of confusion that we have found ourselves in from time to time are as follows:

You recall two years ago the advisability of giving inoculations was questioned and there was a threat to stop all inoculations if poliomyelitis cases occurred in the community. This idea has practically died out, too, except in epidemic areas. You remember the many dollars wasted on spraying cities by airplanes to control this disease, and yet some of these same cities allowed garbage to collect for flies to breed in. One year ago it was decided that gamma globulin was of value in preventing poliomyelitis. Gamma globulin was provided by the National Foundation for Infantile Paralysis and the Red Cross through the State Board of Health for the prevention of poliomyelitis. I decided recently to review the literature to see what convalescent serum or gamma globulin was good for, and I find it has been used for many diseases in the past. It appears that today we think that gamma globulin is of value in the control of measles (rubeola), infectious hepatitis and agammaglobulinemia, and is of questionable value in poliomyelitis. You know the status of gamma globulin today for the prevention of poliomyelitis; we cannot say it is of value and cannot say that it is not. Mumps convalescent serum may be of value in the prevention of mumps.

Handling Gamma Globulin

I need not tell you of the many problems that have come to us in the handling of gamma globulin during the past year, because you, too, have shared in this experience. We have had worthy requests for gamma globulin from all of Florida and from Cuba and Costa Rica. We have tried to comply with the regulations set up for the distribution of this biological. The part that practicing physicians have played in the handling of gamma globulin should be commented upon. We have been informed by many practicing physicians that they wanted us to set up regulations for the distribution of gamma globulin since it is not available on the market. They wanted us to stick by the regulations because it made their task easier in meeting the requests and demands of their patients. On the other hand, some physicians much prefer to get their biologicals at the drug store and not from the state. We have been alert to the possible problem of black market in the gamma globulin distribution by the state, but I am happy to report that this has not been a problem, or it has not been brought to our attention if it has occurred.

It has been recommended that gamma globulin now be used only for group inoculations in groups larger than the single family. We expect to have more gamma globulin available to us this year than last year. We plan to continue to make gamma globulin available to direct contacts and neighborhood contacts as prescribed by the attending physician as long as gamma globulin is made available to us. The dosage perhaps should be increased to an average of 10 cc. per case rather than an average of 7 cc., which has been used.

We have tried to analyze the cases of poliomyelitis that have been reported to our office. It is noted that there has been a definite shift in pattern to cases occurring in the older ages. One would expect more cases in the younger group since there has been an increase in the population in the younger children. The increase in the cases among the older age group appears to be significant, based upon the cases reported during the years from 1946 through 1953.

Our experience in Florida, as you know, is that polio occurs in every month of the year; however, the peak months are between August and October.

New Vaccine

During the last three months we have devoted considerable time to collecting data, as well as to

making plans for administering the new poliomyelitis vaccine. It was decided that the vaccine would be offered in Dade, Broward and Palm Beach counties. We were led to think that the vaccine would be ready for administering by March 29. Plans were made in the three counties and committees formed for action, but there has been a continual postponement on the date the vaccine would be available. Now it appears the vaccine will be available, but it is too late to carry out the undertaking called for because schools will soon be closed. This postponement means not all children will complete the series of vaccinations; we are nearing the peak of the poliomyelitis season. The vaccine may be too late to be effective this year in Florida. The status of this situation at the present is this: The vaccine was to have been given to the second grade pupils in these three counties. Because of the lateness in the school year, Dade County decided ten days ago not to offer the vaccine in that county this year. Last week Monroe County asked to give the vaccine, and the request has been approved. The vaccine for that county will be administered about May 17. We expect Broward and Palm Beach counties to get their vaccine within a few days.

Sample blood tests will be made on 2 per cent of the school children in the first, second and third grades prior to administration of the vaccine and then two weeks after the third injection. Possibly a third blood test will be made this fall. The purpose of the blood test is to evaluate the antibody production powers of the vaccine. The results of this field trial experience will not be known for probably a year. The number of cases of poliomyelitis occurring in the second grade will be compared with the number of cases that occurred in the other two grades in each of these three counties. As you know, this same study will be conducted in 44 different states this year.

Public Interest

The general public has been most interested and willing to assist on the problem of poliomyelitis; however, it sometimes appears that some of the plans and the timing of plans and announcements that have been carried out have had more than one purpose. Many of the national plans are too premature, and the result is that many of us health officers have had to bear the brunt of telling the public the facts. There surely should be more coordination of information given to the press with that of service to the public through the health departments.

The purpose of this paper is not to belittle the efforts that have been made in the control of this disease by all agencies concerned, but to try to review with you the health officers' many problems. The chances are that poliomyelitis will develop in few people in your community during an epidemic. This fact is borne out clearly in that many insurance companies will sell you a family poliomyelitis insurance policy for a fee of $6.50 to $10.00 per year for $5,000 insurance for a man and his wife and children under 18. Rates for a single person range from $2.75 to $5.00. The case rate in most communities has never grown as great as a rate of one per thousand per year even in epidemics. Our state case rate last year was 23.6 per 100,000 or .23 per 1,000. You can see, therefore, that the insurance companies are not taking much of a chance when they sell you a poliomyelitis insurance policy.

Summary

This paper reviews some of the problems faced by the health officers. Our efforts in the control of poliomyelitis are dependent upon knowing more about the disease. We hope that the field trial vaccine findings will prove to us that we have found a vaccine that gives protection. It may be, however, that we are simply going through another stage in the control of poliomyelitis similar to the ones we have experienced in the past. I believe experiences like we have had with poliomyelitis are what make our task as health officers interesting and challenging.

1828 Cherry Street.

A. M. A. CLINICAL SESSION
MIAMI, NOVEMBER 29-DECEMBER 2, 1954

Treatment of Intractable Pain

Harold Carron, M.D.
TAMPA

Intractable pain may be defined as pain which cannot be completely relieved by the use of narcotics or other analgesic drugs. Pain of this nature occurs with direct involvement of sensory somatic fibers, or as a result of reflex vasomotor disturbances. The source of the pain may be irritation of nerve plexuses in the walls of blood vessels, inflamed periarticular ligaments, or direct somatic nerve involvement. In all cases, however, the painful impulses are referred centrally by the ordinary sensory fibers. Intractable pain can frequently be relieved by breaking the reflex arc by chemical or surgical interruption of the nerve pathways, by excision of a pathologic section of artery, or by infiltration of the sensitive ligaments of a joint with a local anesthetic.

Pain is a complex mechanism, and the patient with intractable pain frequently presents a perplexing picture. Nerve block therapy should not be a mere technical procedure. Sufficient time should be spent in obtaining a clear history and performing a careful physical examination to arrive at a satisfactory diagnosis. Such therapy should be reserved for those patients in whom there is clear evidence of involvement of somatic or sympathetic nerve fibers. The patient with diffuse pain unrelated to definite somatic or sympathetic nerve distribution is not likely to benefit from chemical or surgical interruption of nerve pathways. Chemical interruption of nerve pathways should be used diagnostically to determine whether surgical intervention will be of value, as a palliative measure when surgery is contraindicated, and therapeutically when previous experience has shown that chemical interruption of nerve pathways will produce the desired relief of pain either temporarily or permanently. It has been frequently demonstrated that repeated interruption of a painful reflex arc will result in permanent relief in many pain syndromes.

Drugs

There are many drugs useful in the interruption of pain pathways, and the choice depends upon the desired result. The common "local" anesthetic drugs such as procaine, Pontocaine, Metycaine and Xylocaine are of great value diagnostically, prognostically, and therapeutically. Their action is of short duration, and they are effective on somatic and sympathetic nerves and affect both sensory and motor fibers. Repeated or even single injections of these drugs may give effective lasting relief. By repeated injections, permanent relief may often be obtained.

When more prolonged interruption of sensory nerve pathways is desired, one drug has proved of value over a period of time. This is an ammonium sulfate preparation in benzyl alcohol, commercially known as Dolamin. Dolamin affects only sensory somatic fibers, having no effect on motor or sympathetic fibers. Its duration of action varies indefinitely from 48 hours to 14 days. It is nonirritating and nontoxic.

For the permanent or semipermanent interruption of nerve pathways the alcoholic drugs may be used. Commonly employed are absolute ethyl alcohol and benzyl alcohol, the latter being less irritating. These drugs produce complete interruption of motor, sensory and sympathetic fibers for periods varying from six months to two years. Alcoholic preparations are particularly irritating to tissues, however, and may produce painful neuralgias. Their use should be preceded by radiographic confirmation of needle locations.

Treatment of Somatic Pain

Somatic pain usually follows a definite nerve root distribution and is extremely amenable to chemical interruptions of nerve pathways. Cranial nerve neuralgias, particularly of the trigeminal nerve, exhibit excellent therapeutic response to

the intraneural or perineural injection of alcohol following diagnostic procaine block (fig. 1). In involvement of the vocal cords with carcinoma or tuberculosis, injection of the superior laryngeal nerve will render those conditions asymptomatic pending surgery or give relief when surgery is

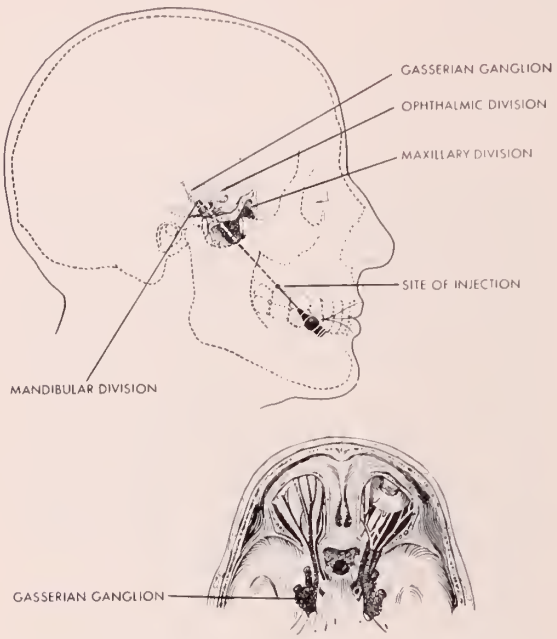


Fig. 1.—Gasserian ganglion block by härtal route.

contraindicated. Phrenic nerve block may be used for the relief of diaphragmatic pleurisy or in persistent hiccups. Relief of pain in carcinomatous involvement of the cervical glands may be obtained by block of appropriate cervical nerve roots (fig. 2).

Brachialgia and phantom limb pain may be alleviated by injection of the brachial plexus (fig. 3). The suprascapular nerve may be readily blocked as it passes through the suprascapular notch (fig. 4). Suprascapular block is probably the most valuable of all nerve block procedures in daily practice and produces the greatest relief in the treatment of subdeltoid bursitis, supraspinatus syndrome, periarticular fibrosis or traumatic involvement of the shoulder joint and arthralgia not responding to conservative therapy. It should be used in conjunction with physiotherapy and manipulative procedures when indicated.

Intercostal block, either paravertebrally at the intervertebral foramens or along the course of the nerves, will immediately relieve the pain of rib fractures, intercostal neuralgia, herpes zoster, thoracotomy, and pleurisy of pulmonary or cardiac origin. It is also of value in relieving postoperative incisional pain, particularly when drugs such as Dolamin are used (fig. 5).

Lower lumbar and upper sacral nerve block aids in the differential diagnosis of low back pain and is of therapeutic value in the supportive treatment of ruptured intervertebral disk, and in sciatica, arthralgia of the hip, and acute back injuries (fig. 6). Perineal pain due to carcinoma of the prostate, cervix or rectum with involvement of the caudal fibers is usually relieved for several weeks through the use of caudal analgesia with ammonium sulfate preparations, and prolonged relief is obtained through the use of subarachnoid alcohol. The use of subarachnoid alcohol, however, should be reserved for terminal cases of malignant disease, for frequently there is interference with bladder and bowel function.

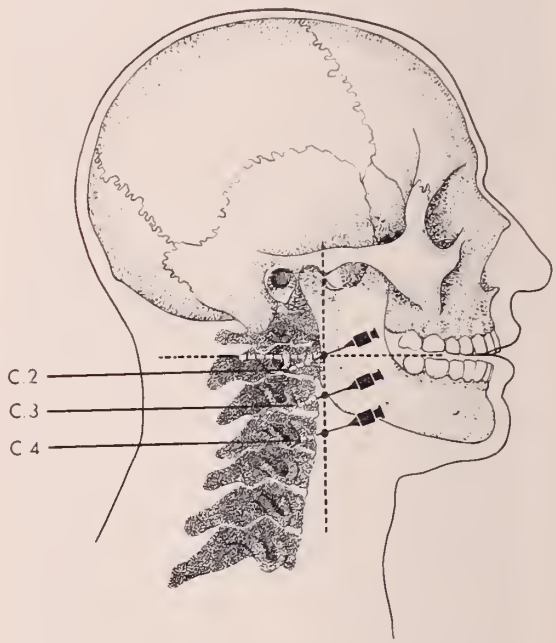


Fig. 2.—Sites of injection for cervical plexus block.

Sympathetic Nerve Blocks

Reflex vasomotor disturbances result from irritation of nerve plexuses in periarticular tissue or walls of blood vessels, or from direct nerve injury, producing what is known as causalgia. Causalgia is characterized by hyperesthesia of the affected part, usually an arm or leg, and may follow even

a trivial injury, particularly in the region of a peripheral nerve. The pain varies from a burning sensation to a torturous throbbing. The affected extremity is cold, cyanotic, edematous, and sweaty. The causalgic patient is constantly protecting the extremity from contact with his environment.

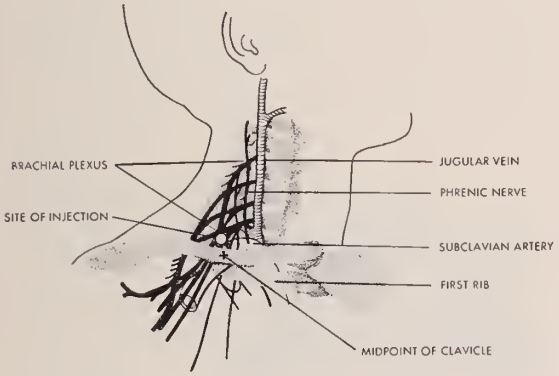


Fig. 3. — Brachial plexus block.

Most commonly causalgia involves the shoulder and arm, and is caused by reflex disturbance of sympathetic centers resulting from what is usually a minor injury to the shoulder or hand. Sudek's atrophy will produce a similar picture. There is frequently a tender area at the anterior aspect of the shoulder joint with gnawing pain in the arm, swelling, hyperesthesia, cyanosis and pain in the hand with inability to flex or extend the

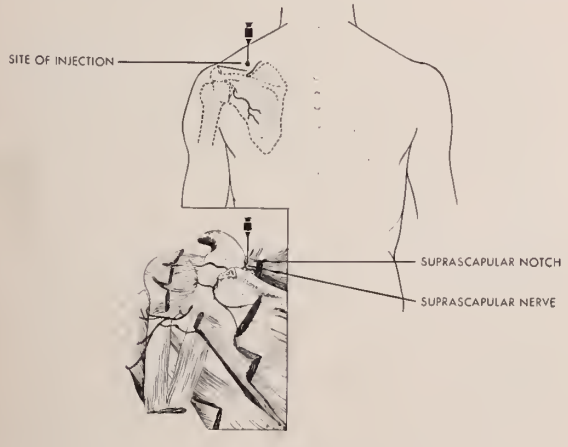


Fig. 4. — Suprascapular nerve block.

fingers. Immediate relief of pain follows dorsal sympathetic or stellate ganglion block with almost complete return of function of the entire extremity within 30 minutes after the injection (fig. 8). When a single injection of one of the short-acting local anesthetics does not confer persistent relief, ganglionic or sympathetic block of more prolonged duration may be obtained through the use of the longer-acting depot blocking agents. In chronic cases in which there is periarticular fibrosis, manipulation of the joint under anesthesia should be done following the block and active exercise instituted.

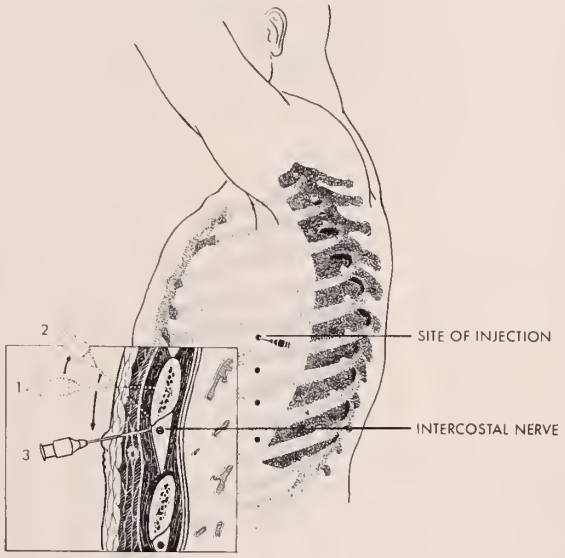


Fig. 5. — Intercostal nerve block.

Thrombophlebitis may be classified with causalgia, for it also results from a sympathetic dystrophy. Venous thrombosis results in a reflex spasm of the involved extremity with findings similar to those of causalgia. Paravertebral sympathetic block or epidural block with a short-acting local anesthetic will produce immediate improvement in the color of the extremity as well as relief of pain and swelling (fig. 8). Acute epiresection of the second and third lumbar ganglia acting drugs until the circumference of the involved extremity is normal. Chronic thrombophlebitis, due to direct trauma or occurring postoperatively, may be successfully treated even years after the onset of the condition by sympathetic block with one of the longer-acting local anesthetics such as procaine in oil or alcohol. Arterial emboli in the upper extremity may be

treated by upper dorsal or stellate ganglion block and those in the lower extremity by repeated lumbar block or continuous spinal or epidural block.

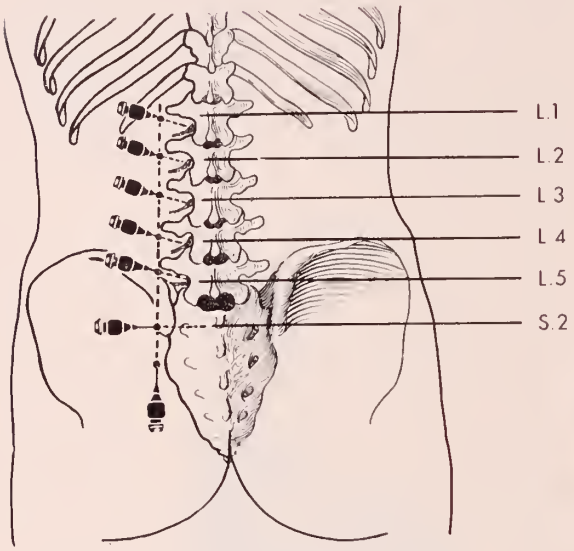


Fig. 6. — Lumbosacral nerve block.

In table 1 the indications for each of the most commonly utilized nerve blocks are listed. Diagrams (figs. 1-8) indicate the pertinent anatomy involved in each of these therapeutic procedures. Discussion of the technic of these procedures may be found in any of the texts listed in the references.

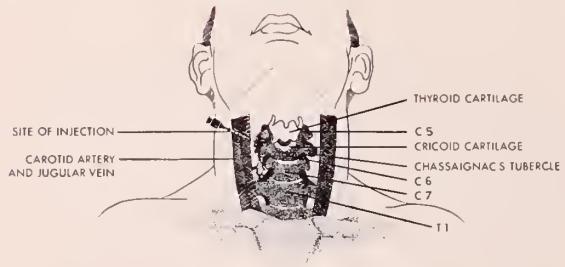


Fig. 7. — Cervicothoracic sympathetic block.

When sympathetic block has given complete relief for only a short period of time in chronic cases of causalgia or thrombophlebitis, upper thoracic sympathectomy in the case of the arm or resection of the second and third lumbar ganglia in lower extremity involvement is reasonably certain to succeed. In that case in which diagnostic block has been followed by no response or when sympathectomy has failed, what to do next becomes a major problem. Posterior nerve root section is of little value. Intrathecal injection of alcohol is occasionally successful and can be tried in cases of causalgia or amputation stump neuralgia in the lower extremity. Section of the spinothalamic tract, however, as high as the second cervical segment, is the only measure that can be counted on to give relief in pain syndromes not responding to block therapy. Prefrontal lobotomy will produce excellent results and should be considered when other measures fail.

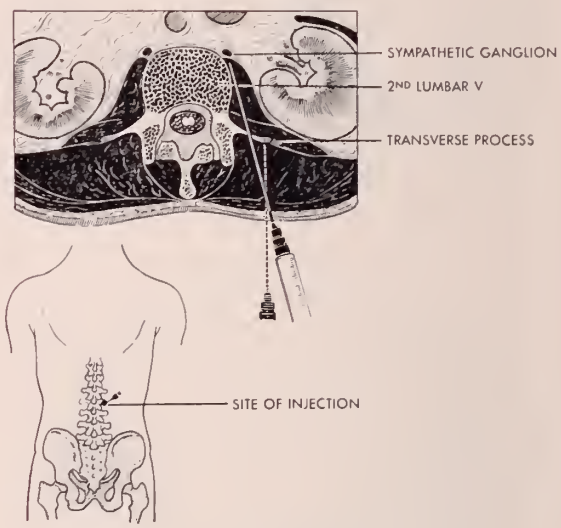


Fig. 8. — Lumbar sympathetic block.

Stellate Ganglion Block

Stellate ganglion block deserves special consideration. Many papers have been published relative to its merits in the treatment of cerebrovascular accidents. The use of stellate block is predicated on the assumption that much of the paralysis and muscular spasm is due to reflex spasm of cerebral vessels in the area surrounding the infarction. Experience has shown that the best results are obtained when the block is done within the first 24 hours of cerebral thrombosis or embolism. In most cases of this type aphasia will improve, and often within a matter of minutes the patient will become able to move the previously completely paralyzed extremity. In cases of cerebral hemorrhage, block should not be undertaken during the acute episode for fear of increasing the bleeding. Results in the chronic cases have been disappointing.

Table 1. — Indications For Various Nerve Blocks

TRIGEMINAL NERVE
- Tic douloureux
- Herpes of the V nerve
- Painful fractures of the mandible

SUPERIOR LARYNGEAL NERVE
- Carcinoma of the larynx
- Tuberculosis of the larynx

PHRENIC NERVE
- Diaphragmatic pleurisy
- Persistent hiccups

BRACHIAL PLEXUS
- Brachialgia
- Phantom limb pain
- Causalgia of upper extremity

SUPRASCAPULAR NERVE
- Subdeltoid bursitis
- Supraspinatus syndrome
- Periarticular fibrosis of shoulder joint
- Trauma to shoulder joint

CERVICAL AND THORACIC SYMPATHETIC NERVES (STELLATE)
- Causalgia of upper extremity
- Frostbite
- Raynaud's disease
- Acute vascular occlusion
- Cerebral thrombosis and embolism
- Sudek's atrophy of upper extremity

INTERCOSTAL NERVES
- Rib fractures
- Intercostal neuralgia
- Herpes zoster
- Thoracotomy
- Pleurisy
- Postoperative pain

LUMBAR SYMPATHETIC NERVES
- Causalgia of lower extremity
- Acute occlusion of arteries
- Thrombophlebitis
- Peripheral vascular disease
- Frostbite
- Sudek's atrophy of lower extremity

LUMBAR AND SACRAL NERVES
- Supportive treatment herniated disk
- Low back pain
- Arthralgia of the hip
- Acute back injuries
- Perineal pain due to carcinoma of rectum, cervix, prostate

Most gratifying have been those results obtained in patients who have been paralyzed for three to six months following a cerebral thrombosis. Approximately 75 per cent of these patients will show an immediate improvement in walking and a decrease of spasm of the paralyzed lower extremity. A few patients will either become able to move a previously completely paralyzed arm or will gain movement in one partially paralyzed. The postparalytic pain in many of the chronic cases of cerebral thrombosis is due to Sudek's atrophy, and the treatment indicated is ipselateral stellate and lumbar sympathetic blocks following a therapeutic contralateral stellate block.

Conclusion

Nerve block therapy from the standpoint of useful drugs, the treatment of somatic pain, sympathetic nerve blocks, and stellate ganglion block is discussed.

The early block treatment of pain syndromes in the region of a joint should be emphasized, for early relief of pain will often prevent permanent limitation of motion at the joint and decrease considerably the period of morbidity.

Complete and thorough evaluation of each patient will aid in the selection of those subjects in whom good results might be expected from nerve block therapy. In the more complex pain problems, neurologic and psychiatric consultation is desirable and recommended.

The patient with intractable pain is a problem not only to himself and his family, but also to the physician whom he consults for treatment. Prime consideration should be given to all methods for relief of pain before the patient is consigned to narcotics for the duration of his existence.

References

Adriani, J.: Techniques and Procedures of Anesthesia, Springfield, Ill., Charles C. Thomas, Publisher, 1947.
Cullen, S. C.: Anesthesia in General Practice, Chicago, The Year Book Publishers, Inc., 1946.
Southworth, J. L., and Hingson, R. A., editors: Conduction Anesthesia: Clinical Studies of George P. Pitkin, Philadelphia, J. B. Lippincott Company, 1946.
White, J. C., and Smithwick, R. H.: The Autonomic Nervous System, New York, The Macmillan Company, 1946.

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Dinner Key Auditorium

American Medical Association
EIGHTH ANNUAL CLINICAL SESSION
November 29 MIAMI December 2

Across the entire nation physicians and their wives are planning to converge on Miami late this month for the Eighth Annual Clinical Session of the American Medical Association. America's only tropic metropolis is ready to receive in its own inimitable way the host of visitors who plan to take advantage of this unique opportunity to enjoy a combined business and pleasure trip to Florida's vacationland. Florida is proud to have this great gathering within its borders, and every member of the Florida Medical Association is happy to join the Dade County Medical Association in extending a hearty welcome. All join in the sincere wish that those who come on this occasion will benefit professionally from the exceptional program of graduate medical education, will have fun in the sun, and will depart with recollections so delightful as to insure an early return.

The clinical sessions will be held in Dinner Key Auditorium, where ample accommodations are assured. There is a large parking area for those who will use their own cars. Bus and taxi service from all the leading hotels also will be available. The auditorium boasts an excellent restaurant as well as a snack bar. The conveniences are such and the program so arranged that the visiting physician, who comes in the morning, can stay all day for there is something to do, to see, and to hear every minute from early morning until late afternoon.

Opening General Session

On Monday morning, November 29, at the opening general session there will be welcoming addresses by the Honorable Abe Aronovitz, Mayor of the City of Miami, Dr. Edward W. Cullipher, President of the Dade County Medical Association, and Dr. Duncan T. McEwan, President of the Florida Medical Association. The principal lay speaker will be the Honorable LeRoy Collins, Governor-Elect of the State of Florida. Dr. R. L. Sanders, President of the Southern Medical Association, will be the principal medical speaker.

Scientific Program

Subjects of broad interest in the fields of medicine, surgery, pediatrics, neuropsychiatry, obstetrics and gynecology comprise the scientific program. Eminent lecturers from all over the country, authorities in their respective fields, will discuss the various subjects and answer questions. In addition, there will be a dozen symposiums and panels. Many of the practical everyday problems of the physician will be covered. The program will be geared particularly to the interests of the general practitioner, but there will be much to interest the specialist in every field.

First among the symposiums highlighting the program is the one on "Sterility," scheduled under Obstetrics and Gynecology on Monday afternoon, with Dr. Robert A. Ross serving as moderator. On Tuesday morning four symposiums and one panel are featured. "Trauma" is the subject for the two under Surgery, the first dealing with head injuries, chest injuries, extremity fractures, shoulder injuries and spine injuries; the second covers hand injuries, maxillofacial injuries and hip fractures. The two under Obstetrics and Gynecology are on "Pelvic Carcinoma," with Dr. Herbert E. Schmitz as moderator, and "Obstetrical Hemorrhage," with Dr. F. Bayard Carter as moderator. The subject for the panel discussion under Medicine is "Modern Concepts in Chemotherapy of Pulmonary Tuberculosis," with Dr. Jack Reiss serving as moderator. The symposium scheduled for Tuesday afternoon under Surgery is on "Facial Pain." The two symposiums on Wednesday also are presented under Surgery; the subject of the one in the morning is "Vascular Diseases" and of the one

in the afternoon "Malignancies," the latter covering malignant disease of the stomach, colon, cervix and breast. Included in the final program on Thursday morning are two symposiums under Surgery, one on "Jaundice," with Dr. Richard D. Cattell as moderator, and the other on "GI Bleeding," with Dr. Alton Ochsner as moderator. Also on that morning under Medicine a panel discussion on "Hypertension and Arteriosclerosis" will be moderated by Dr. Victor Kugel. The subjects of the many papers to be presented cover a wide range from "Use and Abuse of Cortisone" to "How NOT to Treat Children" and "Ten Psychosomatic Problems."

Scientific Exhibit

Eighty notable scientific exhibits will comprise the Scientific Exhibit, which will be continuously in session from early Monday morning until Thursday noon. Researchers and active practitioners, serving as demonstrators, will be on duty throughout to present latest technics and findings and to answer questions and discuss problems with the visiting physician. Here leading members of the profession are readily available to their colleagues as nowhere else, making the Scientific Exhibit an unsurpassed short course in postgraduate medical education.

Special features will include the Fracture Exhibit, with leading surgeons conducting demonstrations. The Exhibit Committee on Fractures has arranged for conference room facilities and suggests that interested physicians bring their x-ray films of cases they wish to discuss.

The treatment of burns, cardiac surgery, ulcerative colitis and varicose veins are among the subjects of other surgical exhibits.

Several times each day experienced obstetricians will present manikin demonstrations on "Problems of Delivery." Among the subjects for exhibits on obstetrics and gynecology are toxemias of pregnancy, cesarean section and trichomonas vaginalis infection.

Comprising the group of exhibits on medicine will be practical demonstrations on the diagnosis and treatment of cardiovascular diseases, tape recordings of heart sounds and breath sounds, exhibits on diabetes, peptic ulcer, arthritis, amebiasis and gastrointestinal disorders. In the displays on neuropsychiatry practical information is offered on strokes, cerebral palsy, epilepsy, parkinsonism, and the use of the newer drugs in these conditions. Among the numerous other subjects on which presentations will be made are pediatrics, urology, hay fever and allergy, audiology and speech correction, noise and hearing, rehabilitation, cancer and pathology.

Scientific Films

Motion pictures on subjects of interest to the physician in general practice will be shown continuously in a room adjacent to the Scientific Exhibit. There will be approximately 12 of these pictures, and many of the doctors will be present to discuss their films.

A special film program on Tuesday night at the Hotel McAllister will feature, among other films, a premiére showing of two outstanding motion pictures, entitled "Lung Cancer: The Problems of Early Diagnosis," sponsored by the American Cancer Society, and "Differential Diagnosis of the Arthritides (Rheumatoid, Osteo, and Gouty)" by Dr. William B. Rawls of New York, who will present it. Also selected for presentation is a film entitled "Congenital Malformations of the Heart," which was prepared by Dr. Robert Rushmer of the University of Washington in Seattle. It presents the embryology, origin, and functional significance of congenital malformations of the heart which produce cyanosis.

Color Television

Medical color television will come to Florida for the first time when it assumes its usual prominent role at the Clinical Session. A highlight of important medical meetings since 1949, it should evoke unusual interest on this occasion. The colorcasts, originating from the operating suite of the 930 bed Jackson Memorial Hospital, will bring the operating room directly into the lecture hall at Dinner Key Auditorium. Two 4 1/2 by 6 foot screens will receive the colorcasts.

Sponsored and produced by Smith, Kline & French Laboratories in cooperation with the American Medical Association, color television is always one of the most enthusiastically received presentations in the over-all scientific activities at the A.M.A. meetings. The closed circuit medium possesses certain special advantages for postgraduate gatherings. In this instance, the telecasts cannot be seen on any screens other than those at Dinner Key Auditorium. Also, the program can be adapted readily to the interest of the particular group for whom it is being televised, yet within that area topics differing widely in their method of presentation can be covered.

There is an immediacy in the "live" telecasts not associated with films. In addition, the drama of the unexpected always is associated in a special way with operations.

Color is of course a major asset of the medium. It permits presentation of subject matter which is dependent on color for identification, and surgery gains the definition essential to a realistic view of the operative field.

The development of production technics has made possible a variety of effective methods available to the surgeon for the presentation of operations. He may choose between giving a straight running narrative as he operates, carrying on a question and answer discussion with a member of the operating team, holding a round table discussion with other surgeons watching the operation on a monitor located in the studio, or switching periodically to an assistant in the studio who discusses and demonstrates clinical material pertinent to the operation.

Scheduled well over a year ago, the medical color telecasts for the Clinical Session have been in course of preparation for many months. The preliminary detail work for their production constitutes a major undertaking and affords an excellent example of the cooperative effort in every quarter which insures the success of this meeting.

Technical Exhibit

Fortunately, Dinner Key Auditorium has sufficient area to accommodate both the scientific and the technical exhibits as well as the meeting rooms all on one level. The Technical Exhibit will be centered between the two outstanding attractions, the clinical meetings in the west section and the scientific exhibits in the east section.

A recent survey disclosed that 44 per cent of the physicians of this country prescribe a new product for the first time as a result of conversations with detail men from pharmaceutical houses. The exhibits at the Clinical Session afford the physician an exceptional opportunity to view at first hand the latest tables, instruments and gadgets and to talk with the officials of the drug houses whose products they have been prescribing for years. Here is an ideal means of acquiring knowledge of the newest products.

Almost every important ethical medical and appliance firm in the nation will be represented in the Exhibit. These organizations present attractive, informative displays, which often portray graphically and concisely the whole story of a particular product. They invite physicians to register at the various booths, to talk with the representatives in attendance, and to comment freely on their products. They deserve the support and interest of every physician, primarily because of their products, but also because the fees the exhibitors pay for their space cover a major portion of the meeting expense and thus afford physicians the privilege and the stimulus of such a meeting.



House of Delegates

More than 300 delegates to the American Medical Association will assemble in the Flagler Room of the Hotel McAllister for meetings of the House of Delegates. No more truly democratic body will be found in America, and the association's members are privileged to see the House in action as the delegates they have elected to represent them debate the vital issues of the non-scientific aspects of the complex practice of medicine as it exists today.

Many physicians attending the Clinical Session will find the committee meetings of the House among its most interesting activities. Here the general membership may discuss the resolutions. The chairmen welcome the attendance of the A.M.A. members and appreciate their participation in these hearings. The committee meetings afford the average American physician ideal sounding boards for his feelings and opinions on any appropriate matter. They also are good places for him to learn how many other physicians share his viewpoint.

Most physicians who attend the Miami Clinical Session will wish to avail themselves of the opportunity to see the House of Delegates in session. Taking a first hand view of how their A.M.A. is run will be profitable to them and pleasing to their delegates. Florida's representatives in the House are Drs. Reuben B. Chrisman Jr., Miami, Herbert L. Bryans, Pensacola, and Louis M. Orr, Orlando.



Recreation

The recreational facilities of the Greater Miami area are legion. Entertainment and amusement attractions run the gamut from sight-seeing, shopping, sunning and swimming to fishing, golfing, racing and night clubs. Tropical Park race track will be open, greyhounds will be running at Biscayne Kennel Club, and big name stars will be appearing in the many night clubs. In addition to the golden sands of the beaches dotted with coconut palms, there are hundreds of fresh water and salt water swimming pools complete with cabana facilities to appeal to the swimmer. There are some 600 varieties of fish to be caught in Miami waters. Fishing enthusiasts may troll for sailfish, dolphin, marlin and other big gamesters in the Gulf Stream, or plug and fly casting fans may bring their own equipment and try their luck over reefs or whip streams and lakes. A dozen golf courses are in the area. Sightseeing attractions range from stately mansions and priceless estates to Seminole Indian villages and nearby Everglades National Park.

Of interest to all Miami visitors is the International Airport, which is always a scene of busy activity, with 60 airlines using its facilities. This airport handles 47 per cent of the nation's international air passengers and more import-export air cargoes than all others combined by nearly 500 per cent.

The University of Miami has the only entirely new postwar campus in the nation, and its modernistic architecture commands widespread interest among visitors. Its medical school, now in its third year of operation in temporary quarters, is Florida's first, and a medical school building is now being constructed by the University at Miami's Jackson Memorial Hospital. The first experiments in the use of cobra venom to combat polio were conducted by the University in the laboratory of the Miami Serpentarium, another sightseeing attraction of special interest to physicians, where snake venom is extracted daily for medical research.

Plans for the Ladies

Miami's famous hospitality will be extended in unstinted measure to the wives of physicians attending the Clinical Session. They are invited to check in at the Courtesy Corner in the Columbus Hotel where the Woman's Auxiliary to the Dade County Medical Association, under the leadership of Mrs. Robert F. Mikell, President, and the co-chairman, Mrs. Richard F. Stover, President of the Woman's Auxiliary to the Florida Medical Association, will be waiting with numerous plans to make their visit a memorable one. The Auxiliary has arranged a special tour, a cruise to fabulous Villa Vizcaya, estate of the late James Deering, and other entertainment will be available in abundance to please even the most fastidious taste. While no formal women's meetings are planned, Mrs. George Turner, President of the Woman's Auxiliary to the American Medical Association, will be in attendance and will give her report to the House of Delegates.

Postconvention Medical Meetings

The Jamaica Branch of the British Medical Association has invited members of the American Medical Association to attend its official meeting, which is scheduled for Saturday, December 4, immediately following the close of the Clinical Session on December 2. Kingston, capital city of Jamaica, where the meeting will be held, is only three hours by airliner from Miami. Elaborate plans have been made by the Jamaican doctors for the entertainment of the American visitors and for their reception by Jamaica's Governor. Also, official representatives of the American Medical Association have been asked to participate in the scientific program.

The Haiti Medical Association has extended an invitation to the American physicians attending the Clinical Session to come to Port-au-Prince, Haiti, for a postconvention Seminar scheduled for December 3 to 7. An extensive scientific and social program has been prepared for the occasion. The social highlight will be a reception by the President of the Republic of Haiti. A special tour from Miami has been arranged by the American Express Company.



Local Committees

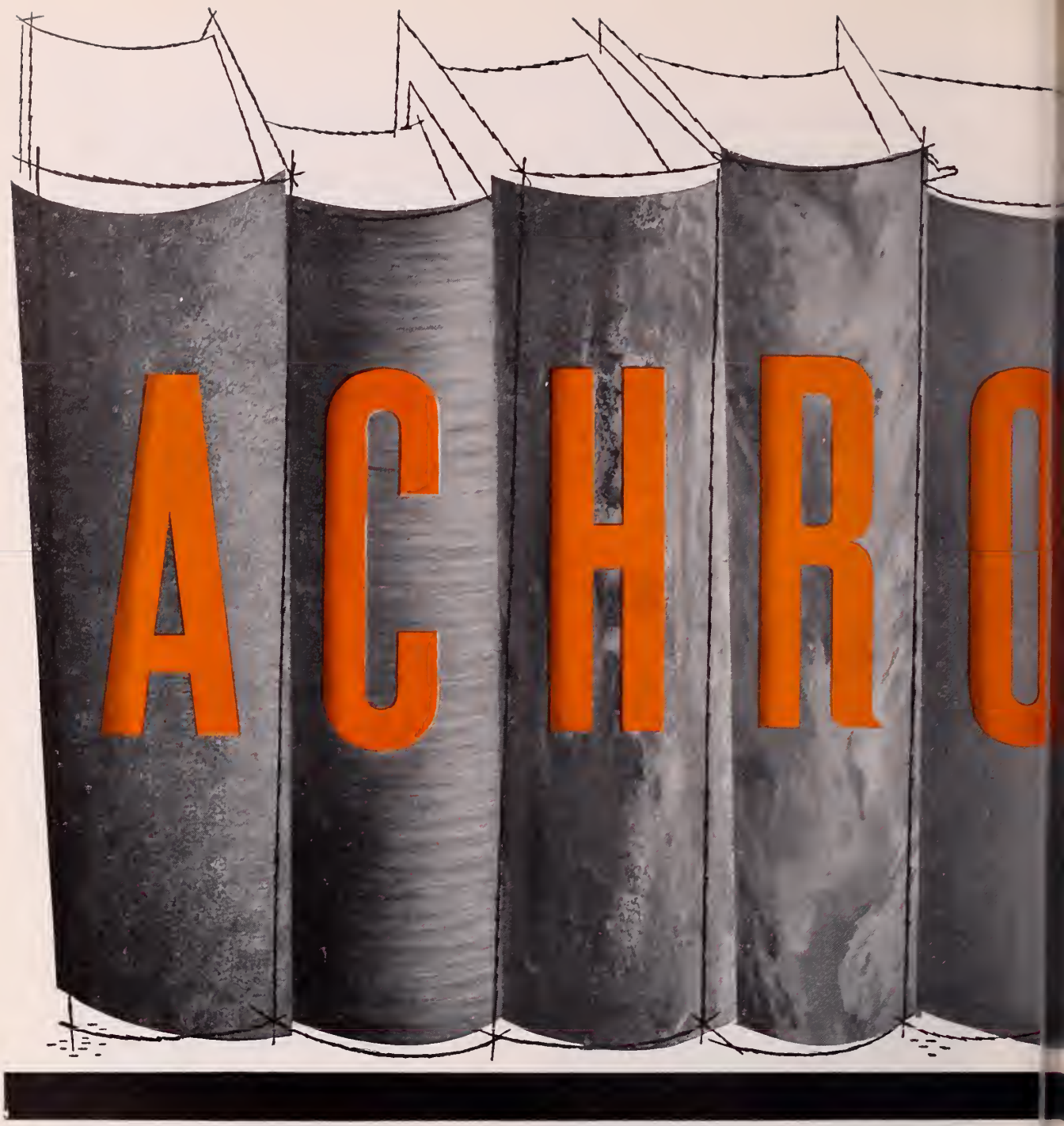
When Miami was chosen for the Eighth Clinical Meeting, the physicians of Florida, and especially Dade County, were well aware of the big responsibility they had accepted. They were, however, nothing daunted, for Miami has long been geared to entertaining on a large scale and in the grand manner. Miamians in general, and physicians of the Greater Miami area in particular, have no qualms about playing host to gatherings great or small. The General Chairman for the Clinical Session is Dr. Homer L. Pearson Jr., who is as much at home in A.M.A. circles as in the medical affairs of his state and county. He for years represented the Florida Medical Association in the House of Delegates and is now serving a third term as a member of the Judicial Council of the American Medical Association. The Vice-Chairman is Dr. Reuben B. Chrisman Jr., who is also much at home in the A.M.A. House of Delegates.

Heading the General Committee is President Cullipher. Co-chairmen of the Program Committee are Drs. Ralph W. Jack and Ralph S. Sappenfield, and subcommittee chairmen are: Surgery, Dr. Walter C. Jones; Medicine, Dr. Franz H. Stewart; Obstetrics and Gynecology, Dr. John D. Milton; Pediatrics, Dr. Warren W. Quillian; Neuropsychiatry, Dr. James L. Anderson; and General Practice, Dr. John E. Dees. Dr. George F. Schmitt Jr. is chairman of the Committee on Scientific Exhibits, and Dr. L. Washington Dowlen heads the Committee on Color Television. Co-chairmen of the Committee on Finance are Drs. Duncan T. McEwan and John D. Milton. Dr. Joseph S. Stewart is chairman of the Committee on Entertainment; subcommittee chairmen are: Golf, Dr. Charles R. Burbacher; Fishing, Dr. Richard F. Stover; and General Sports, Dr. Manual A. Schofman.

Other committee chairmen are: Opening Session, Dr. J. Raymond Graves; Hotels, Dr. Hunter B. Rogers; Information and Publicity, Dr. Robert F. Dickey; Registration, Dr. Frazier J. Payton; Hospitality, Dr. Wiley M. Sams; Transportation and Sightseeing, Dr. Hollis F. Garrard; Attendance, Dr. Donald F. Marion; and Women Physicians, Dr. Martiele Turner.

There is every promise of a truly great meeting of which Florida and Miami may long be proud. Do not miss it.

(Application for Hotel Accommodations, page 399)



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From Our President

See You in Miami

On behalf of the 2,600 members of the Florida Medical Association, it becomes my high privilege to extend cordial greetings and a warm welcome to the officers and members of the American Medical Association who will be in attendance upon the Eighth Clinical Meeting of that great organization, to be held in Miami November 29 through December 2. Florida Medicine is honored to have this opportunity to extend its hospitality to physicians and their families from far and near.

Every effort has been made by the Dade County Medical Association to insure the success of the meeting. Its committees in charge of arrangements have sought diligently to perfect every detail, and their preparations have been so well planned and thorough that benefit will accrue to all. They may be proud indeed of the outstanding scientific program. They are famed hosts, and the Greater Miami area is well known for its unique and numerous attractions.

Nature promises a riot of color at that time of year. Too, the weatherman all but guarantees average 75 degree temperatures. Along with scientific stimulus and delightful associations with old friends and new, all may anticipate plenty of fun in the sun.

In my official capacity, I look forward to greeting many physicians from across the nation, and I also expect to greet a record number of Florida physicians. Let us all here in Florida have a share in making this great occasion a memorable one for every visitor as well as for ourselves.

Duncan McEwen

The Journal of the Florida Medical Association

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The A.M.A. Comes to Florida

Eighth Clinical Session

November 29-December 2

The Florida Medical Association has the good fortune this month to welcome to the state and to Miami the American Medical Association. The holding of the Eighth Clinical Session of that organization at Dinner Key Auditorium in Miami, November 29 through December 2, is a major event in Florida's medical history. It bespeaks the state's great progress of the recent past which makes it possible to have a medical meeting of that magnitude in the tropic setting of the nation's southernmost metropolis in this far southeastern state.

The Association's largest component society, the Dade County Medical Association, is to be congratulated upon the masterful approach it has made through long months of planning and hard work to insure complete preparation in every detail for an outstanding meeting. The setting is delightful. The scientific program is excellent. All speakers are nationally known for their professional achievements, and the program has been arranged to allow ample time for discussion. The recreational attractions of the Greater Miami area are innumerable and unsurpassed. Experienced and ideal hosts await the visitors, eager to comply with their every wish.

In the Clinical Session section of this issue of The Journal there is a resume of the convention plans which will encourage every member of the Association to take advantage of the exceptional opportunity to attend this great meeting right on his own doorstep. Undoubtedly all members will wish to do so, and all who possibly can will join the trek to Miami with the out-of-state visitors to share with them the professional benefits and the pleasures offered.

The Editors of The Journal are happy to unite with the officers and members of the Association in extending a hearty welcome to all who are Florida-bound for this great occasion.

Thanksgiving

O Lord! That lends me life,
lend me a heart replete with thankfulness.
Shakespeare

It has been truly spoken by a great American that the soul of our America is its freedom of mind and spirit in man, that here alone are the open windows through which pour the sunlight of the human spirit, that here alone is human dignity not a dream, but an accomplishment. Who in this great nation can bespeak no thanks this holiday? Surely no citizen who is mindful of his heritage.

Cultivation of a keener interest today in American history offers a bulwark against the spread of Communism and other un-American ideologies. There is a perennial lesson in the struggles of the pioneer settlers of the vast wilderness that once was America, in the dauntless courage with which they faced cruel hardship and extreme danger, and in the abiding and abounding faith in God and in themselves through which they triumphed. Once this lesson is firmly implanted in the minds and souls of America's youth, they cannot fail to be inspired by the example of those who built the great institutions they are privileged to enjoy. No Communist doctrine can counteract, no propaganda filled with false promise can shake the patriotism of those who believe, as did the founding fathers, that freedom of the individual is a divine blessing bestowed upon all mankind by the Creator of the universe.

With time, the land frontiers have passed, but even now the frontiers of science are barely opening. With all its high promise this new domain can and will be conquered only by men inspired from the concepts of free spirit. Medicine is not laggard. It has its McDowell, its Beaumont, its Reed, today's members of the Walter Reed Society, and many others, mostly unsung heroes, to offer inspiration from past accomplishments. It has the future beckoning to new goals on an ever widening horizon. And above all, there is always today, always the present challenge, always the opportunity to do what clearly is at hand. On this year's Thanksgiving Day, is there a physician in this land of the free so indifferent, so callous as not to be proud and thankful to have a part in America's pageant of progress in medicine?

The Role of Stress in Modern Medicine

Stress is steadily gaining recognition as an important contributory cause of disease. Although its role remains at present ill-defined, it is nevertheless conceded that there are many kinds of stress, which play a prominent part in numerous diseases in ways not now well understood. The effects of stress vary widely and have bearing upon every branch of medicine.

A recent editorial[1] listed the diseases in which stress was credited with a major role as duodenal ulcer, thyrotoxicosis, malignant hypertension, thromboangiitis obliterans, ulcerative colitis, rheumatoid arthritis, and the collagen diseases; types of stress included such widely different factors as infection, intoxication, trauma, muscular and nervous fatigue, extreme heat or cold, and irradiation, all of which elicit from the body a similar response. It was stated that stress implies either an inner conflict or a conflict against circumstances for which no immediate action is appropriate; also it implies further that the conflict is protracted, the outcome uncertain, and that the victim is constantly aware of it.

The great difference in the ability of different persons to withstand what appears to be the same amount of stress without evidence of breakdown has been observed by many authors. It is concluded, however, that no one is immune from breakdown if the stress is sufficiently severe and prolonged.

A research team in Korea, consisting of physiologists, psychologists, and psychiatrists, found by tests on the blood, urine, and saliva of infantrymen who had been under almost constant artillery bombardment for five days, but with only 7 per cent casualties, that they were much worse off than those who had experienced 18 hours of intense fighting during which the unit sustained 70 per cent casualties. Severe adrenal exhaustion was noted in the men who had been in combat five days, while adrenal reserve and output were above normal in the other group. Severe dehydration was present in the group subjected to the shorter more intense exposure to stress even though the supply of water was ample in their canteens. "This suggests that stress may suspend normal thirst even though water loss continues at a normal or accelerated rate."

Studies of the research team revealed a drop in leukocyte count following combat like that associated with severe burns, the blood changes not returning to normal after five days. Too, the enormous individual variation in reaction to stress applied in all fields. In explanation, one theory advanced was that the same pattern of exhaustion is common to all, but persons operate at different speeds. The man tiring easily is affected faster, not more, than the one who tires less readily. The other theory ascribes the varying effects to the different emotional reactions to stress exhibited by different persons, conditioned by their past experiences. It was observed also that some breakdowns are violent but brief, and others, while less violent, are prolonged.

Prevention of course is better than cure. Aside from removal of the cause, which is the best treatment, other therapeutic measures advocated are rest, a change of scene and a change of interest. This intriguing subject invites widespread study for only continued investigation of the relationship between stress and bodily changes will clarify current ideas about it and the stress diseases.

1. Stress, J. A. M. A. 155:981 (July 10) 1954.

The Doctor's Wife Lives Public Relations

If marriage is always a demanding career, and few would say that it is not, surely it is particularly challenging to the doctor's wife. Of necessity the medical profession makes special demands upon marriage. Quite as much as the individual physician needs specialized training for his chosen field, his wife needs to develop special skills in making their marriage compatible. She must be an expert of sorts — executive, homemaker, diplomat, social secretary, educator, not to mention sundry other roles.

In addition to the attributes essential to any stable lifelong union — love, good judgment, discernment, tolerance, patience and good humor — there are certain qualifications that the doctor's wife requires in greater than usual degree. Essentials for success in her exacting role are good habits of thought and behavior in relation to people, and the understanding of human problems. Others are good taste in personal grooming, discretion and restraint in conduct, and orderliness in her environment. Add to these the ability to plan efficiently, and of course with sufficient elasticity to meet the exigencies of the situation. There is always the busy telephone; there are always the uncertain hours and the special social and civic obligations to disrupt the most carefully planned timetables.

It has been aptly and truthfully said that the doctor's wife lives public relations. The unique position in the community which becomes hers with matrimony she must keep by her own efforts. While she shares in some measure the esteem accorded her husband in the community, she nevertheless must earn regard for herself in her own right. By sincerely, diligently and discreetly trying to further his professional interests, she may enhance his prestige, and by thoughtless word or foolish act she likewise may "make the best of intentions a matter for venomous castigation."

An important field of public relations in which the physician's partner in marriage well may tread warily is that of organizations and affiliations. Wisely, she will be a cautious joiner, remembering that in whatever enterprise she engages, although acting on her own, she implicates her husband. In lending her name, she also lends his sacred possession. By taking care to be sure of what she is sponsoring, she avoids embarrassment to her husband and his profession as well as to herself. Especially should she approach money-raising ventures with caution.

To be an ally of good public relations, publicity must be carefully handled, whether in the press or simply the spoken word. There are times when the art of silence, of tactful evasion, or of feigned ignorance should be an automatic reaction. Ignorance, though feigned, often may have greater rewards than mere bliss. In contacts outside the home, one of the richest assets of the doctor's wife lies in the excellent opportunities for friendship. This reciprocal relationship comes about through mutual attraction of minds and hearts, to which tactlessness, gossip and inconsiderate behavior are a deterrent.

A pleasant telephone personality is truly a triumph in public relations for the physician's mate. Certainly all within the doctor's household who answer the telephone or meet patients should be adequately trained to handle these contacts, and the wife may best impart this training by precept.

Surely no one needs to cultivate good health habits more than the doctor's wife. Too, every doctor's family needs a family doctor other than the doctor in the family. Also, the wife must keep

pace with her husband, broadening her life with his through the years so that, with success, she will not be the girl he left behind him. It is her privilege to bring to him something of the cultural advantages of the community for which he has no time, and also to share his interests and hobbies.

These are but some of the highlights of a pen portrait of the successful doctor's wife, published in September as one of a series of essays by authorities and entitled "The Physician and His Practice."[1] The author of this particular essay, Kathryn L. McCabe, sees in the nuptial ceremony the debut to a rewarding life for the physician's mate. All the special qualifications and considerations required to be successful as the wife of a doctor, however, suggest to her the words of Robert Browning:

. . . Love, we are in God's hand.
How strange now looks the life he makes us lead;
So free we seem, so fettered fast we are!

The doctor's wife is to be congratulated upon the admirable way in which she usually meets the special demands the difficult business of marriage places upon her. By inclination and training physicians are discerning men, wise in human relations and keen in judgment. Fortunate are they indeed to have partners of comparable astuteness and wisdom.

1. McCabe, Kathryn L.: The Doctor's Wife, in The Physician and His Practice, edited by Joseph Garland, M.D., Boston, Little, Brown and Company, 1954, pp. 24-37.

Postgraduate Study for Foreign Physicians

Under the auspices of the American College of Surgeons, the Foreign Operations Administration will bring 100 European physicians to the United States for postgraduate study. The project will cost $480,500. Specialists will study for periods varying from six weeks to three months. Younger men will stay for a maximum of three years. All types of medical specialists are to be invited, and much of the study will be designed to acquaint the foreign physicians with the technics of American hospitals. Local committees in the various foreign countries will make the selections. The American College of Surgeons is under contract to the Foreign Operations Administration to direct the entire operation.

Gerontological Society Meets in Florida December 28-30

The Seventh Annual Scientific Meeting of the Gerontological Society will be held at the University of Florida in Gainesville on December 28, 29 and 30, 1954, in collaboration with the Annual Southern Conference on Geronotology.

The program of this national organization includes scientific papers in the fields of biology, social sciences and clinical medicine. The chairman of the program committee is Dr. Edward Bortz of Philadelphia. In view of the wide clinical interest in geriatrics, many members of the Florida Medical Association will find this outstanding program of particular interest.

The Secretary of the Gerontological Society, N. W. Shock, Ph.D., of Baltimore, advises that room reservations should be sent, prior to December 15, to Mr. F. T. Adams Jr., General Extension Division of Florida, University of Florida, 707 Seagle Building, Gainesville.

Florida Physician Honored

The American Roentgen Ray Society, on the occasion of its fifty-fifth annual meeting held in Washington, D. C., late in September, elevated to its highest office an eminent Florida roentgenologist. Dr. Joshua C. Dickinson of Tampa has long served his specialty with distinction both in the state and in the nation, and he acceded to the presidency of this national organization for the current year well equipped to give wise and vigorous leadership. Outstanding among his colleagues across the years as the ardent champion of clinical radiology, he chose for his presidential address "The Art of Clinical Radiology," a subject in which he is well versed from personal experience.

"If radiologists will be real clinicians," he declared, "we need have no fear as to the future of our specialty. . . . The radiologist who bases his opinions upon the fact that a given film looks like something he has seen before is a picture reader and not a clinical radiologist. . . . If in the conduct of his examination the radiologist confers with the patient, makes such examinations as he thinks may be indicated, takes the history intelligently, displays a personal interest in the problem and, upon completion of the examination,

tells the patient that he will discuss the problem with the referring physician, that patient knows that he has seen a doctor. Also, he realizes that the radiologist's contribution is of importance because of the professional opinion rendered and that the responsibility no longer rests solely on the referring doctor. If a radiologist is to fulfill his obligation to the patient, he must know the pertinent factors in order to discuss the case intelligently with the physician who has referred the patient to him."

It was Dr. Dickinson's opinion with regard to therapeutic radiology that it is just as absurd for a surgeon to presume to tell a radiologist when, where and how to treat as for a radiologist to attempt to tell a surgeon when, where and how deep to cut. This able clinician also made a strong plea for training residents in radiology not alone in research and the mastering of complicated gadgets but also in the concept of the patient as an individual like themselves, beset by social, economic, and personal stresses as well as those particularly medical.

His colleagues in the Florida Medical Association congratulate this staunch and forthright member upon whom the mantle of national leadership of his specialty has fallen and they wish him well in his arduous task.

OTHERS ARE SAYING

The Real A.M.A.

Many colleagues display a perverse delight in castigating the A.M.A. In this pleasurable pursuit, they are joined by nonmedical (but professional) critics who oppose every action of the A.M.A., or gleefully deplore any A.M.A. hesitancy to take precipitate, hasty, and ill-considered steps. On occasion, we have taken pot-shots at our parent organization when it seemed proper, but to shoot without a thorough understanding or without realizing why no action was taken, obviously is the act of a child-brain.

Let's look over the physical plant which is ours; let's examine the many A.M.A. activities and functions; let's analyze who runs the thing, what makes it tick?

Located at 535 North Dearborn Street in Chicago is a nine-story granite building, the heart and nerve center of the American medical profession. Almost one thousand workers keep the wheels turning. The grist of this mill is fed the American public, this represents about 140,000 physicians.

The activities in this A.M.A. building range from the three-floors-and-basement full-scale publishing plant to lawyers carefully studying proposed legislation; from white-coated technicians analysing pills and potions to the production of television and radio programs.

Some people think the A.M.A. devotes most of its energy to fighting "progressive action and socialized medicine." And, yet, about 60 per cent of all revenues (circa $9,000,000) are spent on scientific activities. Everyone knows the A.M.A. Journal — it is one of the best. This alone costs $4,000,000 a year. Everyone knows also the A.M.A. monthly journals in the various specialties, plus scores of books and thousands of brochures, pamphlets, and reports. The thirteen presses run on a two-shift basis.

"Council Accepted" is a part of the average physician's vernacular. Behind these two words are several "Councils." They study drugs, food, cosmetics; and a jillion other matters — in fact, anything and everything pertaining to health or medicine. Other departments consider medical education, medical licensing, and hospital-service standardization. Still other departments handle quack and nostrum complaints. Too few physicians use the magnificent library service which is theirs for the asking. Twice a year, the A.M.A. presents great scientific exhibits.

Most physicians aver our A.M.A. spends an overwhelming bulk of its income on "fighting socialized medicine." Last year the A.M.A. spent $385,000 on "public relations"; this might be construed disparagingly as the none-too-subtle "fight against socialized medicine." Yet, most of this obviously was honest-to-goodness, legitimate

"public relations", and not in a "fight agin" anything. It takes the same amount just to maintain card index files on each M.D. — one of the nine floors is so allocated.

As stated before, there is no phase of medicine or public health (in the broadest sense) which is not represented in this, our gigantic organization. Naturally, much time, effort, and money must be spent to carry out these manifold functions; this is necessarily so, and will continue. Inevitably, some colleagues get disgusted when their own particular pet grievance is not handled posthaste; when their own private opinion is not immediately foisted and broadcast to the American people. Of course they get irritated and damn the A.M.A.!

Who runs this "medical octopus", as it has been described? Well, most of these various councils and committees have full-time M.D.'s or laymen as secretaries, with top-flight physicians serving in an unselfish manner, to carry out their respective council and committee functions. We have a Board of Trustees (sometimes referred to as "a bunch of senile fossils", or, again as "medical politicians"). We have a President, and the other usual officers, and we have a general manager and secretary, Doctor George Lull. The general characteristics of these gentlemen is well-known.

First, they usually are in "medical politics" for many years before they are elected Trustee (if we mean by "medical politics" that they have faithfully served their County and State medical societies). We think this is a badge of merit — not a stigma of opprobrium. Second, this does make a guy conservative, somewhat slow to act, probably deliberate in policy. Most physicians are inclined to be "not the first nor yet the last" in their thinking. And, given fellows like this, let them practice until they're fifty or sixty, let them work in County and State medical organization jobs for twenty or thirty years, you will find men whose inherent conservatism has been potentiated by two or three decades of service in the harness — hence, the bitter, but unjustifiable, "fossil" appellation.

Unfortunately, at times these Trustees have been swayed by some clever, brilliant, dominating personality. That's bad! These Trustees include "freshmen", apt to be influenced by older and ostensibly wiser heads. Occasionally, a bunch of Trustees are more sluggish than they need be to accept newer ideas but, in general, our Trustees are a fair cross-section of a fine bunch of gentlemen doing their best. And they are, first of all, fellow-physicians. Let's remember that!

Sometimes, when we hear colleagues gripe about the A.M.A., we wonder. Do they actually know what they're talking about; have they spent any time or effort trying to establish the facts or the background of the A.M.A. official policies or activities? Do they read the A.M.A. Journal; do they answer questionnaires; do they alert themselves on current events in "medical politics", before they speak? Or do they just lambaste or damn the A.M.A. without knowing whereof they speak, merely because the A.M.A. seems such an impersonal, nebulous something, and a convenient whipping-boy? In this connection we are reminded of the irate father who comes home to find the side of the barn (or, what's worse, the house) covered with mud-balls, and immediately starts raising hell about the neighbor's kids, only to find it was his own brats who were the miscreants.

The guys who run the A.M.A. are us! When we sit on our dead derrieres (dern rears to you Missourians!), and let the "medical politicians in Chicago" do this or not do the other; when we cuss them out, remember we are cussing out fellow-physicians who are making a personal sacrifice to do our organizational work.

The proper way to handle these gripes is to vote on every local medical society election, to serve as an officer to the best of our abilities when elected, and *to raise hell with (or change) our elected representatives* when things aren't going to suit us — the noisy axle gets the most grease!

. . . V. T. Williams, M.D.

—*Kansas City Medical Journal, May-June, 1954*

EIGHTY-FIRST ANNUAL MEETING

FLORIDA MEDICAL ASSOCIATION

ST. PETERSBURG

APRIL 3-6, 1955

The Medical Society and the Public Press

The medical profession has become accustomed to public criticism and alleged dissatisfaction. In large part, this has been due to misunderstanding, lack of good public relations and perhaps especially to our failure to present our side of the picture. Too often we have addressed the public only from a defensive position. Is not a stronger offense long overdue in this field?

Certainly it would appear to be quite in order that greater effort and more time should be expended in the direction of informing the public about the functions and activities of the County Medical Society.

The practice of medicine is a public service. The County Society is dedicated to serve both its members and the lay public. It behooves the Society to expand its scope and sphere of influence to create a common meeting ground for the two.

It is suggested that the public press be utilized much more by our Society than it has been. A regular news column emanating from the Society could be invaluable in clarifying issues.

For too long, the medical profession has had no avenue to answer the many "ghosts" which have been laid at its door. The defections of a small minority have received front-page publicity. How often is this taken by the laymen to indicate that bad practices are rampant?

In all fairness we need a medium to answer charges against the profession. We should also draw attention to the tenets we uphold and the things we oppose. And finally, we should frequently remind the public of the many ways in which we stand as guardians of their health.

—*Westchester (New York) Medical Bulletin, July 1954*

American Medical
Association
Clinical Session
Miami
Nov. 29 - Dec. 2, 1954

STATE BOARD OF HEALTH

Audiovisual Materials Available

The following audiovisual materials are available to physicians from the Florida State Board of Health, Jacksonville. Please address requests to the Film Library and give two weeks' notice whenever possible.

Sixteen Millimeter Films

Breast Cancer — The Problem of Early Diagnosis (30 Minutes. Color). — This film is the second in a series of films on diagnosis of cancer sponsored by the American Cancer Society and National Cancer Institute, United States Public Health Service. Portions of the film are in animation and clinical photography with excellent shots of breast examination.

Gastrointestinal Cancer — The Problem of Early Diagnosis (30 Minutes. Color). — The third in a series of films on diagnosis of cancer, this film shows the common symptoms manifested in each of the following conditions of the gastrointestinal tract: cancer of the esophagus, stomach, small intestine, colon and rectum. The latest methods of diagnosis in each are given.

Uterine Cancer — The Problem of Early Diagnosis (20 Minutes. Color). — This fourth film in a series on the early diagnosis of cancer illustrates the practicability of reducing deaths from cancer of the uterus and cervix. It emphasizes the importance of smear studies and shows excellent clinical and laboratory material. The film is sponsored by the American Cancer Society and the National Cancer Institute.

Oral Cancer — The Problem of Early Diagnosis (30 Minutes. Color). — Another in the series of films on the early diagnosis of cancer, this film stresses the importance of close cooperation between the dentist and the physician in the early detection of growths. It gives a clinical picture of six types of mouth cancer: gingiva, tongue, floor of the mouth, palate, cheek and lips. Also, it gives statistics on the percentage of cure in each type.

Congenital Malformations of the Heart (Color): Part I. Development of the Normal Heart (20 Minutes); Part II. Acyanotic Congenital Heart Disease (20 Minutes); Part III. Cyanotic Congenital Heart Disease (30 Minutes). — This group of three motion picture films in color was

produced by the University of Washington Medical Department. These films are examples of the best in teaching material for practicing physicians, interns, and medical students.

In the first reel the early development of the heart from a common tube in the chick embryo has been photographed on motion picture film. Initiation of the electrical impulse in the area eventually to be a portion of the right auricle is clearly shown. Thereafter animated drawings in color are employed to illustrate the development of the various septa. The circulation of the blood is depicted in the fetal and in the extrauterine state. Reels two and three are devoted to an excellent demonstration of most of the malformations of the heart and great vessels.

Slides

Congenital Malformations of the Heart

1. Development of the normal heart from the primitive cardiac tube
2. Acyanotic congenital malformations of the heart
3. Cyanotic congenital malformations of the heart

A 2 by 2 slide series made from the film on congenital malformations of the heart which permits a more leisurely review.

Roentgenograms of the Heart and Great Vessels

A series of 51 lantern slides made from selected roentgenograms of the chest for professional use in teaching and arranged in groups as follows:

1. Roentgenograms of the normal heart and great vessels
2. Displacement of the normal heart and great vessels
3. Rheumatic heart disease
4. Arteriosclerotic-hypertensive heart disease
5. Syphilitic heart disease
6. Congenital anomalies
7. The heart and great vessels in pulmonary diseases

The Circulatory System

A series of 35 mm. slides in color prepared for use in nursing education, depicting the fetal and adult circulations and some of the more common congenital malformations of the heart and great vessels. (A tape recording of comments on the slides is in preparation)

Tape Recordings

Present Status of Dietary Versus Endogenous Cholesterol in the Pathogenesis of Atheromatous Disease

A lecture by William Dock, M.D., Professor of Medicine, New York University College of Medicine. This tape is accompanied by a short filmstrip containing tables and graphs referred to in the lecture. Recording speed 3 3/4 inches per second, dual track, time 20 minutes.

Comments on Low Salt Syndrome

A lecture by G. E. Burch, M.D., Professor of Medicine, Tulane University of Louisiana School of Medicine. Recording speed 3 3/4 inches per second, dual track, time 20 minutes.

The tapes described are suitable for play back on home tape-recording equipment.

Heart Sounds

A series of eight 7-inch reels for use in teaching clinical auscultation of the heart. These were prepared by the Department of Medicine, Georgetown University Hospital and Georgetown University School of Medicine, under the direction of W. Proctor Harvey, M.D. The tapes are recorded at a speed of 7 1/2 inches per second, single track, on special equipment, and for the highest fidelity play back it is recommended that professional tape recording equipment be borrowed from your local radio station. The tapes are accompanied by Dr. Harvey's reprint describing their use in teaching clinical auscultation of the heart.

YOUR BLUE SHIELD

Blue Shield Physicians Please Read This Carefully — It is of Importance to You

If you have not yet sent in your application for Active Membership in Blue Shield of Florida, Inc., please do so before it is too late — it is important to you.

The Importance of Active Membership

Only through Active Membership can Blue Shield physicians truly participate in their Plan. Only through Active Membership may participating physicians vote for the Directors who are to represent them on the Blue Shield Board of Directors, and only through Active Membership may participating physicians have a voice in the

affairs of the Corporation. Also, only Active Members are eligible to be nominated for election to the Blue Shield Board of Directors. There are no dues to pay for Active Membership — no obligations to fulfil.

The Necessity for Applying for Active Membership

The By-Laws and Charter of Blue Shield of Florida, Inc., specify that application for Active Membership is to be made to the Executive Committee of the Plan, and that admission, or election, to Active Membership is to be by vote of the majority of the members of the Executive Committee. Accordingly, an application for Active Membership was sent to each participating physician, along with a request that the application be returned to the Plan in order that it might be presented for election to the Executive Committee.

Participation at Annual Meeting

The annual meeting of Blue Shield of Florida, Inc., is to be held in April, 1955, at the time of the annual meeting of the Florida Medical Association in St. Petersburg. Only duly elected Active Members will be eligible to vote and participate at this meeting. The last time that the Blue Shield Executive Committee is scheduled to meet before the Annual Meeting of Active Members is on the fourth Sunday of January, 1955. Physicians who do not return their applications in time to be presented to the Executive Committee for election at the January meeting will not be eligible to vote and participate in the Annual Meeting in April. *If you have not already sent in your application for active membership you are urged to do so immediately.*

Medical Officers Returned

Dr. Thomas J. Stewart, who entered military service on Oct. 14, 1953, was released from active duty on Aug. 9, 1954, with the rank of captain, MC, U. S. Army. His address is Century.

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. Charles D. Cooksey of Jacksonville announce the birth of a daughter, Melanie, on Sept. 14, 1954.

Dr. and Mrs. Daniel R. Usdin of Jacksonville announce the birth of a daughter, Lisa Anne, on Sept. 18, 1954.

Dr. and Mrs. Marcus B. Bergh of Orange Park announce the birth of a daughter, Susan Christie, on Sept. 23, 1954.

Marriages

Dr. Harry F. Watt and Mrs. Lois O. Creekbaum, both of Ocala, were married on Sept. 8, 1954, in Tampa.

Deaths — Members

Bouchelle, Louis B., New Smyrna Beach	Sept. 5, 1954
Feldman, Joseph, Palm Beach	Oct. 7, 1954

Deaths — Other Doctors

Vaughn, Cecil, Tampa	Nov. 24, 1942
Hampton, W. H. (Col.), Lakeland	Oct. 18, 1949
James, Henry W. (Col.), Jacksonville	Nov. 9, 1949
Moore, Johnson M., Penney Farms	Feb. 23, 1952
Osborne, Leroy J., Owego, N. Y.	July 14, 1952
Mas, Juan A., Havana, Cuba	April 19, 1953
Martin, Robert A., Pell City, Ala.	July 10, 1954

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Amato, Louis L., Fort Lauderdale
Barrett, Jack W., Miami
Brady, Louis P., Orlando
Bresler, Emanuel H., Miami
Browning, John D., Fort Pierce
Cantor, Leonard C., Opa Locka
Dickey, James W. Jr., Fort Lauderdale
Epstein, Byron D., Miami
Fields, J. Allan, Fort Lauderdade
Greene, John P., West Palm Beach
Gunion, Frederick A., Miami Shores
Hammond, Morton L., Miami
Lerner, Lee W., Miami
Mikes, Frank L., Pompano Beach
Morton, Glenn H., West Palm Beach
Ruzow, Stanley J., Hialeah
Thomley, Miles W., Orlando
White, La Vere G., Fort Lauderdale
Williamson, Roston M., Homestead

STATE NEWS ITEMS

Dr. Warren J. Brown of Largo was guest speaker at the Kiwanis Club meeting on August 23 in that city.

Dr. Samuel E. Kaplan of Venice attended the nineteenth annual Congress of the International College of Surgeons in Chicago in September. Following the meeting he took a two week postgraduate course in surgery at the Cook County Hospital.

Dr. J. Brooks Brown of Jacksonville spoke on "Smoking and Lung Cancer" at a recent meeting of the American Legion, Post 88. He also showed the movie, "The Warning Shadow."

Dr. John N. Sims Sr. of Live Oak spoke on August 23 before the Rotary Club of Live Oak. His subject was the work that he and Dr. Edward G. Haskell Jr. of Branford are doing on an experimental basis on encephalitis.

President Duncan T. McEwan of Orlando delivered the principal address at commencement exercises for the graduating class of the school of nursing at Orange Memorial Hospital on September 3.

Dr. Grover W. Austin of St. Petersburg was principal speaker at a recent meeting of the Florida Upper West Coast Group of Medical Record Librarians of the American Legion Hospital for Crippled Children. His subject was "Reconstructive Problems Confronting the Plastic Surgeon."

Tulane Medical Alumni will hold a dinner at the Biscayne Terrace Hotel, Biscayne Blvd. and Fourth St., Miami, on Tuesday, Nov. 30, 1954. Cocktails will be served at 6:30 p.m., and dinner at 7:30. Dress is informal. Information will be available in the auditorium. All attending the dinner must register with the young lady on duty. All Tulane students, members, wives, grown children, and friends are cordially invited. Dr. Alton Ochsner will be guest speaker.

Theta Kappa Psi Medical Fraternity will hold a good fellowship luncheon at the Biscayne Terrace Hotel, Biscayne Blvd. and Fourth St., Miami, at 12:30 p.m., Tuesday, Nov. 30, 1954. There will be a young lady at a table in the auditorium with information. All attending the luncheon must register with her. All members, wives, grown children and friends are urged to attend, as members of the Grand Council will be there.

Dr. Samuel M. Day of Jacksonville, Secretary-Treasurer of the Association, extended a word of greeting from the Association at the convention of the Florida State Nurses' Association in Jacksonville November 1-3.

Dr. L. Roland Young of Daytona Beach attended a joint session of the International Mental Health Congress and International Child Psychiatric Association in Toronto, Canada, recently.

Dr. DeWitt C. Daughtry of Miami has returned to his practice after representing the American College of Chest Physicians at inauguration ceremonies of a large chest disease hospital in Santiago, Chile. While there he gave several lectures on cardiac surgery and other thoracic diseases. Dr. Daughtry also lectured in Lima, Peru,

(Continued on page 400)

In Viewing the VA Medical Program . . .

how VA facilities are being used

Patients Discharged During 1951

	TOTAL	SERVICE CONNECTED		NON SERVICE CONNECTED	
TB	21,388	10,550 = 2.1%		10,838 = 2.1%	
NP	47,673	16,530 = 3.2%		31,143 = 6.1%	
GM&S	442,834	51,820 = 10.1%		391,014 = 76.4%	
TOTAL	511,895	78,900	15.4%	432,995	84.6%

The medicol profession recommends thot VA medicol core be mointoined for treotment of oll service-connected coses ond tempororily for oll wortime veterons suffering from tuberculosis or neuropsychiotric disorders of non-service-connected origin, within limits of existing VA facilities, if they connot offord privote medicol core. Generol medicol ond surgicol potients with non-service-connected disobilities (now 76.4% of oll VA potients) should not be entitled to "free" federol medicol core.

SEE YOU IN MIAMI . .

Eighth A.M.A. Clinical Session

November 29-December 2, 1954

HOTELS AND RATES

Hotel	Single	Double or Twin
Alcazar	$ 5.00- 6.00	$ 6.00- 9.00
Alhambra	.....	8.00
Belfort	5.00	6.00- 7.00
Berni	4.00- 5.00	4.00- 7.50
Biscayne Terrace	10.00	12.00-16.00
Columbus—Headquarters Hotel (No rooms available)		
Cortez	4.00	6.00
Dallas Park	.....	.....
El Comodoro	5.00-10.00	10.00
Everglades	6.00- 8.00	8.00-12.00
Leamington	.....	6.00
Liberty	.....	6.00
McAllister—Headquarters Hotel (No rooms available)		
Miami Colonial	5.00- 6.00	8.00-10.00
Miramar	4.00	6.00- 9.00
Paramount	.....	8.00-10.00
Patricia	5.00	8.00
Plaza	5.00	7.00- 8.00
Ponce de Leon	8.00	10.00-12.00
Robert Clay	7.00	8.00-10.00
Towers	.....	7.00- 8.00
Towne Motel	.....	8.00
Tuttle	.....	6.00

A number of excellent motels are located on Brickell Street and South Bay Shore Drive.

If you wish accommodations at a Miami Beach hotel or motels, make direct reservations rather than through the A. M. A. (Miami) Housing Bureau.
All reservations for hotels listed must be cleared through the Housing Bureau and must be received before November 1, 1954. Make your hotel reservations now!
Use the form below and mark your calendar so that you'll be in Miami November 29 through December 2, 1954.

Make your hotel reservation now!

APPLICATION FOR HOTEL ACCOMMODATIONS

Dr. Hunter B. Rogers, Chairman
Subcommittee on Hotels
320 N.E. Fifth Street, Miami, Florida

Please make reservations noted below:

Hotel ..... (First Choice) Hotel ..... (Second Choice)

Hotel ..... (Third Choice)

Single Room(s) @ $ ..... Twin Bedroom (s) @ $.....

Double Bedroom(s) @ $..... Parlor, Bedroom Suite @ $.....

Arrival:....., at ..... a.m. ..... p.m. Departure:..... , at ..... a.m. ..... p.m.

Names of all occupants: **Addresses:**

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(Please attach list of additional names if you do not have sufficient space here.) If you are a Technical Exhibitor, be sure to give name of firm and individuals to occupy room or rooms reserved.

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(Continued from page 398)

and Panama City, Panama, before returning to Miami.

Dr. Robert C. Black of Plant City has retired from active practice after 50 years of service, 34 of which were spent in Plant City.

Dr. Mark E. Adams, formerly of Perry, has accepted the position as prison physician at the Florida State Prison in Raiford.

Dr. Adams attended the meeting of the International College of Surgeons in Chicago, September 7-10.

Dr. Duncan T. McEwan of Orlando, Association President, will give an address of welcome from the Florida Medical Association before the Clinical Session of the American Medical Association in Miami on November 29.

Dr. J. Brown Farrior of Tampa received the Award of Merit in the American Academy of Ophthalmology and Otolaryngology at the recent meeting in New York. This certificate states that the award was presented for distinguished services in the educational programs of the Academy consisting of participation in the scientific program, homestudy courses, scientific exhibits, and instructional courses.

Dr. Irwin S. Leinbach of St. Petersburg spoke on "A Surgeon's Observations of the European Situation in 1954" before the Brotherhood of the Trinity Evangelical Church on September 21.

Dr. Leinbach spoke on "Classification and Treatment of Hip Fractures" at the meeting of the International College of Surgeons in Chicago in September.

Dr. Simon D. Doff of Jacksonville spoke before the Second World Congress of Cardiology and the Twenty-Seventh Scientific Session of the American Heart Association in Washington, D. C., in September. He recommended chest x-rays for members of families having children born with heart defects that cause blueness in the skin.

Dr. William J. Creel of Eau Gallie has been honored by the city council which adopted a resolution requesting that the Brevard Board of County Commissioners name the new bridge across the Indian River in his honor. This honor was bestowed on him as the city's most prominent citizen.

Dr. Franz H. Stewart of Miami, Assistant Editor, has been appointed Professor of Medicine at the University of Miami School of Medicine.

Dr. Samuel G. Hibbs of Tampa is the new psychiatric consultant for the Polk County Guidance Center.

Dr. James J. Griffitts of Miami has been named president-elect of the American Association of Blood Banks. The election took place at the annual meeting of the association in Washington, D. C., in September.

Dr. Griffitts recently spoke at the Fifth International Congress of Blood Transfusion in Paris.

President Duncan T. McEwan of Orlando gave an address of welcome at the Fifth Postgraduate Assembly of the Florida Academy of General Practice on October 17. The meeting was held in Orlando.

Dr. Frederick D. Droege of Arlington, Va., entered medical service with the U. S. Navy on Aug. 25, 1954, with the rank of lieutenant.

Dr. E. Sterling Nichol of Miami spoke at the Second World Congress of Cardiology which was held in Washington, D. C., in September.

Dr. Richard M. Irwin of West Palm Beach entered medical service with the U. S. Navy on Aug. 31, 1954, with the rank of lieutenant commander.

Dr. Sherman B. Forbes of Tampa has returned to his practice after attending meetings of the International Congress of Ophthalmology and American Academy of Otolaryngology in New York in September.

Dr. Herschel G. Cole of Tampa has returned from Europe where he attended the International Academy of Othopedics at Bern, Switzerland.

Of special interest this month to physicians and technicians is the Hematology Seminar, scheduled for November 18, 19 and 20 at the George Washington Hotel in Jacksonville. Dr. William Dameshek, Director, Blood Research Laboratory, New England Center Hospital, Boston, and Clinical Professor of Medicine, Tufts College Medical School, heads the distinguished lecturers. He is the author or co-author of some 250 scientific articles on hematologic subjects and is the founder and Editor-in-Chief of BLOOD, The Journal of Hematology. He will be accompanied by Dr. Zacharias D. Komninos, Research Fellow in Hematology at the New England Center Hospital and Instructor in Medicine at Tufts College Medical School, who also will lecture. His research is centered on the abnormal antibodies in auto-immune hemolytic anemia, a subject on which he has written extensively. Floridians participating in the program are Dr. James N. Patterson, Tampa, a member of the American Board of Pathology, and Dr. John Ross, Director, Jacksonville Blood Bank, Jacksonville. The program was published in the October Journal.

Dr. Maurice L. Jewell of Kissimmee entered medical service with the U. S. Army on September 15 with the rank of captain.

Association members who spoke at the September Woman's Auxiliary conference held in St. Petersburg were President Duncan T. McEwan of Orlando, Dr. H. Phillip Hampton of Tampa, and Dr. Charles R. Sias of Orlando. Also in attendance at the meeting was Mr. Ernest Gibson of the Association's headquarters office in Jacksonville.

Dr. H. Milton Rogers of St. Petersburg will represent the Pinellas County Medical Society on the Board of the Chamber of Commerce of that city.

Dr. Hunter B. Rogers of Miami was among those extending greetings at the opening session of the fourth annual convention of the Licensed Practical Nurses Association of Florida [illegible] meeting was held in Miami, and Dr. Rog[illegible] well resented the Dade County Medical Asso[illegible]

[illegible]tration in

Dr. Clarence D. Rollins of Ja[illegible] every six tended the nineteenth annual Cong[illegible] ternational College of Surgeons in

On December 2, 3 and 4, the Southeastern States Cancer Seminar will hold its seventh annual meeting at the McAllister Hotel in Miami. This Seminar is scheduled to follow immediately after the Clinical Session of the American Medical Association for the convenience of the many physicians who will wish to attend both. The list of distinguished speakers and their subjects appeared in the September Journal.

Dr. Joseph S. Spoto of St. Petersburg has been appointed state physician for the revenue department of the State Road Department.

Dr. George A. Dame of Jacksonville was sworn in as president of the American College of Preventive Medicine at the organizational meeting at the University of North Carolina in September.

Dr. Samuel G. Hibbs of Tampa spoke on "What Makes Us Neurotic?" at a business and educational meeting of the Beta Zeta Chapter, Epsilon Sigma Alpha Sorority on September 1.

Dr. Paul J. McCloskey of Tampa entered medical service with the U. S. Army on Sept. 11, 1954, with the rank of captain.

Dr. Sullivan G. Bedell of Jacksonville was among the speakers at the meeting of the Northeast Florida Association for Mental Health on September 23 in Jacksonville.

The British Medical Association Jamaica Branch, has scheduled its annual meeting at Kingston, Jamaica, on Friday and Saturday, December 3 and 4, 1954, immediately following the Clinical Session of the American Medical Association in Miami. A special invitation has been extended to President McEwan and the officers and members of the Florida Medical Association to attend this postconvention official meeting of the Jamaica physicians. At a special session on [illegible]day morning, December 4, representatives of [illegible]rican Medical Association have been asked [illegible]ate in the program, and in the evening [illegible] a reception, at which the guests will [illegible] Governor of Jamaica. Kings[illegible]ours by air from Miami.

1. Zup[illegible] Practitio[illegible]
2. McHardy [illegible] ation of Metha[illegible] troenterology, J.[illegible]

Dr. John D. Milton of Miami, President-elect of the Association, has been appointed to the faculty of the University of Miami School of Medicine as Professor of Obstetrics and Gynecology.

The University of Miami School of Medicine will sponsor a Symposium on Industrial Medicine on Dec. 3 and 4, 1954. The meeting will be cosponsored by the Industrial Council of the American Medical Association, the American Academy of General Practice, and the Liberty Mutual Insurance Company. Inquiries concerning the Symposium may be obtained from Dean Homer F. Marsh or Dr. William B. Deichmann, chairman of the meeting, Department of Pharmacology, University of Miami School of Medicine, Coral Gables, Fla.

Dr. George R. Creekmore of Brooksville was honored on September 23 with a surprise presentation in recognition of his almost fifty years of service in the practice of medicine. The presentation took place at the banquet meeting of the Pasco-Hernando-Citrus County Medical Society. Dr. Creekmore received a handsome, hand-painted scroll signed by members of the Society and a silver tray appropriately engraved.

The Interim Session of the American College of Chest Physicians will be held in Miami Beach at the Delano Hotel, November 28-29.

COMPONENT SOCIETY NOTES

Franklin-Gulf

The regular meeting of the Franklin-Gulf County Medical Society was held on September 1 in Port St. Joe. Guest speaker was Dr. Lloyd B. Harrison Jr. of Panama City.

Jackson-Calhoun

The Jackson-Calhoun County Medical Society met on September 23 in Graceville.

Lake

At the regular October meeting of the Lake County Medical Society Dr. Russell V. Douglas of Orlando was guest speaker. His subject was "Surgery and the Thyroid."

Dr. Frederick H. Bowen of Jacksonville spoke at the regular meeting on November 3. Members of the Auxiliary met with the Society to hear Dr. Bowen talk on "V.A. and the Private Practice of Medicine."

Members of the Lake County Society are planning to contribute books and periodicals to the new Health Center Library of the University of Florida Medical School.

Pasco-Hernandon-Citrus

At the meeting of the Pasco-Hernando-Citrus County Medical Society on September 23, Dr. George R. Creekmore of Brooksville was honored with a surprise presentation. Dr. Creekmore, who has been engaged in the practice of medicine for nearly fifty years, was presented with a scroll signed by members of the Society and with an engraved silver tray.

Pinellas

The annual meeting of the Pinellas County Medical Society was held on October 4 at the Lakewood Country Club.

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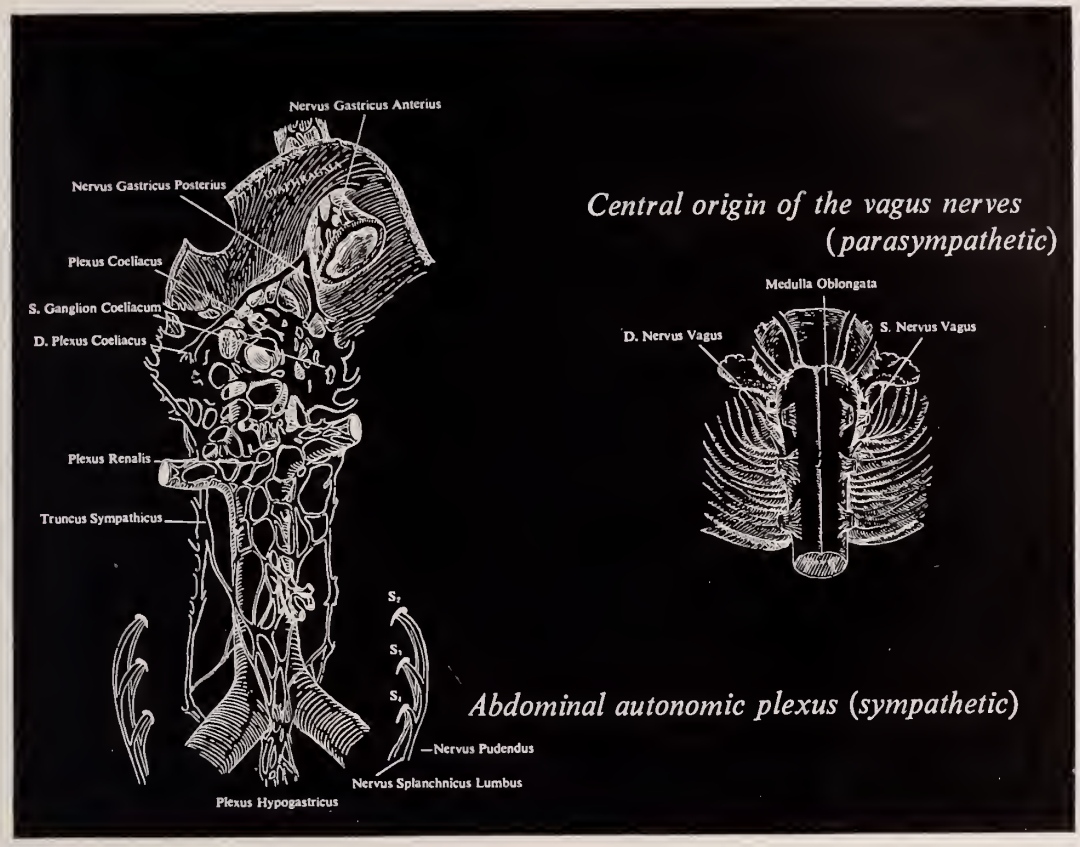
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1. Zupko, A. G.: Pharmacology and the General Practitioner, GP 7:55 (March) 1953.

2. McHardy, G. G., and Others: Clinical Evaluation of Methantheline (Banthine) Bromide in Gastroenterology, J.A.M.A. *147*:1620 (Dec. 22) 1951.

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Firsts, Foremosts, Friendship and Fun at Meeting

Forty-two members of the Florida Medical Auxiliary Executive Board and some of the participating members joined hands at the Tides Hotel, Redington Beach, St. Petersburg, over Tuesday and Wednesday, September 21 and 22, to become better friends and to accomplish the big program set for this year by getting together and doing the necessary business.

The first day was spent on conference work in planning the implementation of the program for the year. I just wish that every member of the Florida Medical Association and the Auxiliary could have been there to see and hear this conference program. The conference was presided over by Mrs. Samuel S. Lombardo, President-elect of the Florida Medical Auxiliary, with her usual poise and understanding. The conference went through on time, and we adjourned at the time that had been set.

Mrs. Richard F. Stover, chairman of *Today's Health* for the Woman's Auxiliary to the American Medical Association, discussed the two programs on this project to be emphasized this year, *Operation Christmas* (a gift subscription for every auxiliary member to augment circulation of *Today's Health* to lay people) and *Operation MD* (a drive to obtain subscriptions from every doctor, many of whom already are taking the magazine but who will have renewals coming up during the year). Mrs. T. Bert Fletcher, Chairman, *Today's Health* for the Florida Auxiliary, stressed our goal in Florida of 200 per cent of our quota of 1,455 subscriptions.

The Woman's Auxiliary is primarily a service organization to its parent, the Florida Medical Association, and particularly to its public relations program. The ways and means we can use of getting information to our husbands and the need for our husbands to have information on the Florida Medical Association and its activities were discussed. We are asking all the doctors in Florida to read some recommended material which will be given to them by their wives. Just as the Woman's Auxiliary is the auxiliary of its members, so the Florida Medical Association is the association of its doctor members. We



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shall do our best to help get information to Association members.

Our interest and enthusiasm for the American Medical Education Foundation was increased through having the statistics given us of the needs of our medical schools. Our goal this year is a total in dollars of our membership ($1,455) and we hope to have reached it by the time of our convention.

One of the most informative and interesting parts of the conference was the informal speech given by Dr. H. Phillip Hampton, Chairman, Committee on Legislation and Public Policy for the F. M. A., on the needed legislation in Florida to assure the health of our citizens. The audience present has gone home with ideas of what we need to do to obtain constructive legislation and ideas on how we can get it done.

The conference ended with a Future Nurses' Club skit telling about what the Future Nurse Club meant to high school students. This skit was put on by the bright and active members of the Future Nurses' Clubs from Northeast and Mound Park High Schools in St. Petersburg. Youth is always refreshing and to see these teenagers with their enthusiasm and their willingness gave all a lift and sent us out feeling that every high school in Florida should have such a Future Nurse Club.

Evening came with friendship and fun emphasized and after a delicious buffet dinner, we had fun with magic. The magician not only performed his tricks but we helped him. Sometime, if you have a chance, ask Mr. Ernest Gibson why it is he can't set a bottle right side up when it is upside down.

The official business meeting came off on schedule the next day at 9:30 a.m.

This was followed by a luncheon at which Dr. Duncan T. McEwan, President, Florida Medical Association, was the guest speaker and spoke on personal responsibilities and personal relationships. He did his usual fine job, and the two day meeting adjourned with all feeling that they had experienced inspiration and understanding during that time.

The Auxiliary is grateful to Mr. Ernest Gibson for his attendance throughout the meeting; to Dr. H. Phillip Hampton for his afternoon with us, his discussion of legislative needs and his staying with us for dinner that evening, — especially since he brought his cute wife with him; to Dr. Charles R. Sias, who came to advise and be with us on Wednesday at the official board meeting and stayed for the luncheon, who brought us the needs of a family doctor for every doctor's family, and we are most grateful for his time and his thoughts and his help. It is indeed a pleasure for those of us who have been active in auxiliary work over a period of years to see and experience the fine cooperation we are having from our Florida Medical Association, and we are deeply appreciative of the sacrifice these individuals made in coming to help us with our problems and to bring us their knowledge and experience.

Our hats are off to Mrs. George H. Anderson, Hospitality Chairman, and to the Pinellas County Auxiliary headed by Mrs. Robert B. Mertz, for the splendid facilities they had obtained and for their fine hospitality while we visited with them. Their board joined with us for luncheon and we were happy to have the chance to renew our friendships with them and to look forward to seeing them at our annual meeting for 1955 in St. Petersburg, where we have now experienced such a meeting as we had on September 21 and 22, a meeting filled with *firsts, foremosts, friendship and fun.*

Mrs. Richard F. Stover, President

A.M.A. CLINICAL SESSION

Miami, Nov. 29-Dec. 2

WOMAN'S AUXILIARY

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OBITUARIES

Paul Howard Martin

Dr. Paul Howard Martin of Jacksonville died in a hospital at Lake City on Sept. 3, 1954 after a long illness. He was 58 years of age. Interment took place in the family plot at St. Elmo Cemetery, St. Elmo, Ill.

Born in Brownstown, Ill., in 1896, Dr. Martin attended Illinois Wesleyan University for three years before enlisting in the United States Army in April 1917. He served in the American Expeditionary Forces in France during World War I and with the occupation forces in Germany. Upon his return to the United States he entered Northwestern University Medical School in Chicago, where he was graduated with honors in 1923. He interned at St. Luke's Hospital in Chicago and spent two years specializing in orthopedic surgery under Dr. Willis Campbell of Memphis, Tenn. Then he came to Jacksonville to enter a partnership with Dr. Frank L. Fort which continued until his death nearly 30 years later.

Locally, Dr. Martin was on the staff of St. Luke's, St. Vincent's, Brewster and Hope Haven hospitals and was also consulting physician to the Veterans Administration. He was Chief of the Orthopedics Department of St. Luke's Hospital and devoted much time to the rehabilitation of crippled children at Hope Haven Hospital. Also, he was active in the Infantile Paralysis Foundation and for many years was orthopedic surgeon for the Florida Crippled Children's Commission in the Jacksonville district. His college fraternity was Tau Kappa Epsilon and his medical fraternity Nu Sigma Nu. He also held membership in Alpha Omega Alpha honorary medical fraternity. In addition, he was a member of the Meninak Club, the San Jose Country Club and the Riverside Baptist Church.

Dr. Martin was a member of the Duval County Medical Society and had been a member of the Florida Medical Association since 1926. He also held membership in the American Medical Association, Southern Medical Association and American Academy of Orthopedic Surgeons.

Surviving are the widow, Mrs. Callie Gilmore Martin, and three children, George, Paula and Catherine, all of Jacksonville; the mother, Mrs. Ella Dillingham Martin, of Springfield, Ill.; and one sister, Mrs. Ronald C. Graham, also of Springfield.

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Peripheral Circulation in Man. By G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and Jessie S. Freeman, M.B., B.S., D.P.H., editors for the Ciba Foundation. Pp. 219. Boston, Little, Brown and Company, 1954.

Recently, a group of world-renowned scientists gathered at The Ciba Foundation in London to discuss current research problems concerning peripheral circulation in man. The papers presented at this symposium have been assembled into a book published in this country under the title "Peripheral Circulation in Man." The book covers the methods for studying blood flow, the changes in circulation due to exposure to cold or heat, the actions of adrenaline and noradrenaline on blood flow, the neurohistology and reflex control of the circulation and the effects of sympathectomy, the significance of cold agglutinins, and the influence of visceral activity on the peripheral circulation. To an understanding of these problems, important workers in this field, whether anatomist, physiologist, biophysicist, pathologist, physician, surgeon, or in aviation medicine, have contributed. The papers are informative and stimulating and offer considerable new information which should be of wide interest.

The Ciba Foundation is an international center, established as an educational and scientific charity under the laws of England. It owes its inception and support to its founder, Ciba Limited of Switzerland, but its distinguished trustees are entirely responsible for its administration. Workers active in medical and chemical research are encouraged to meet at its London headquarters to exchange ideas and information. As one part of the Foundation's activities, informal symposia or colloquia, strictly limited in membership, are arranged, to which leading research workers from different countries and different disciplines are invited. In the first four years of its existence, in addition to many part-day discussions, there have been 24 international symposia, each lasting two to four days, attended by outstanding workers from many countries. Other symposia are planned at the rate of five or six a year. As the smallness of the group necessarily excludes many others active and interested in the subjects discussed, the proceedings are being published and made available throughout the world.



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Medical Licenses Granted

Dr. Homer L. Pearson Jr., Secretary of the State Board of Medical Examiners, has reported that of the 358 applicants who took the examination of the Board, held June 28 and 29, 1954, in Jacksonville, 243 passed and have been issued licenses to practice medicine in Florida. The names and addresses of the 243 successful applicants follow:

Abele, Virgil, Miami (Middlesex 1929)
Alstet, Maynard Hillel, New Orleans (Tulane 1954)
Arey, John Vincent, Mineral Wells, Tex. (Harvard 1946)
Arnold, Gordon Hobart, Bradenton (Tennessee 1954)
Arp, Louis Croft Jr., Iowa City, Ia. (Maryland 1953)
Atcheson, Robert Jones, Jacksonville (Tennessee 1954)

Barron, James, Detroit (Tulane 1940)
Beil, Eugene Edward, Bradenton (Tufts 1949)
Bennett, Willard Hiram Hall, Titusville (Tulane 1954)
Beyer, Damon Pythias, Jacksonville (Iowa 1941)
Bickmore, John Tilghman, Warrington (Cincinnati 1944)
Blakely, Gene Thornton, Jacksonville (Tulane 1954)
Boling, Davis Spratlin, Miami (Emory 1954)
Bonifield, Harold Francis, Inverness (Indiana 1933)
Boyd, Thompson Harmes, Miami Shores (Geo. Washington 1949)
Brooks, William, New Orleans (Tulane 1954)
Canning, Harold Braselton, Wewahitchka (Col. P. & S. Boston 1942)
Caplin, Irvin, Aspinwall, Pa. (Indiana 1939)
Carswell, John Hamilton, Quincy (Georgia 1953)
Carter, William Dorland, Panama City (Iowa 1952)
Caswall, Thomas Marvin, Bartow (Western Reserve 1951)
Chapman, William Lafayette, Sarasota (Tulane 1954)
Citrin, Yale, New Orleans (Tulane 1950)
Clark, Arthur Lee (Col.), Orlando (Howard 1952)
Clifford, Samuel Lawrence, Pensacola (Vanderbilt 1953)
Closson, James Harwood, Gainesville (Hahnemann 1923)
Coleman, Hugh Victor, Columbia, S. C. (South Carolina 1952)
Colmer, William Meyers Jr., Hattiesburg, Miss. (Vanderbilt 1944)
Combes, Lloyd George, Sarasota (Columbia 1939)
Conkling, Frederic Everett III, Miami (Harvard 1952)
Coury, Paul Edward, Bartow (Western Reserve 1951)
Cousar, James English III, Jacksonville (Johns Hopkins 1945)
Crevasse, Lamar Earle Jr., Tampa (Duke 1954)
Crutcher, James Carroll, Brookhaven, Ga. (Duke 1949)

Dame, George M., Jacksonville (Tulane 1954)
Daniels, Richard Eugene, Pensacola (Marquette 1953)
Daurelle, George Paul, Miami (Hahnemann 1947)
Dembrow, Victor David, Brooklyn (Long Island Col. Med. 1945)
Dillard, Edgar Archer Jr., Shulls Mills, N. C. (Pennsylvania 1951)
Dorr, Thomas Wellauer, Tampa (Northwestern 1947)
Dumbauld, Carl Mathews, Gainesville (Jefferson 1923)

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Ekwall, Merton Leon, Jacksonville (Nebraska 1946)
Faulk, Wallace Hunter Jr., Nashville, Tenn. (Vanderbilt 1954)
Faykus, Max Henry, Tampa (Southwestern Med. Sch. 1953)
Feinberg, Samuel Burton, Minneapolis (Minnesota 1946)
Feinerman, Burton, Brooklyn (New York Med. Col. 1954)
Ferreri, Salvador, Tampa (Tulane 1954)
Findlay, Prentiss Edwards, Macon, Ga. (Emory 1954)
Flitman, Donald Blake, St. Louis (Chicago 1954)
Fox, Earl Russell, St. Petersburg (Virginia 1953)
Freeman, Joseph, New York (Louisville 1943)
Gallagher, John Francis, Steubenville, Ohio (Louisville 1933)
Garber, Rudolph Charles Jr., St. Petersburg (Virginia 1954)
George, Charles Lester, Indianapolis (Indiana 1932)
Gerard, Marvin, Dallas, Tex. (New York U. 1954)
Getzen, James Hart, Dade City (Bowman Gray 1953)
Getzen, Lindsay Clonts, Dade City (Bowman Gray 1953)
Gibson, Robert Lester, Jacksonville (Virginia 1952)
Gillett, Robert Lyle, Ann Arbor, Mich. (Michigan 1953)
Gould, Stanley Benton, Baltimore (Geo. Washington 1953)
Goza, George Merlin Jr., Atlanta, Ga. (Emory 1954)
Green, Paul Arnold Jr., Nashville, Tenn. (Vanderbilt 1953)
Greene, Reams Glenn, Nashville, Tenn. (Vanderbilt 1954)
Griscom, John Hooper, Nashville, Tenn. (Vanderbilt 1954)
Grunsten, Russell Carl, Silver Spring, Md. (Geo. Washington 1953)
Hall, Irving Edward Jr., Palma Sola (Cornell 1950)
Hardin, Marvin Smith, Tampa (Temple 1952)
Harrell, George Thomas Jr., Gainesville (Duke 1936)
Harrison, William Henry Jr., Lake Wales (Emory 1954)
Haugen, Roger Kent, Durham, N. C. (Washington 1948)
Hayden, William Lee, Malden, Mass. (Tufts 1954)
Heath, Gordon Read, West Palm Beach (Washington 1952)
Hendrick, James Wesley, Birmingham, Ala. (Tulane 1949)
Hightower, John Allen, Jacksonville (Maryland 1947)
Hinton, Forrest, Immokalee (Hahnemann 1953)
Hirsch, Jay G., Miami (Cincinnati 1954)
Holloman, John James Jr., Edna, Tex. (Texas 1942)
Howard, Paul Edward, Miami (Ohio State 1953)
Hudmon, Isham Stanton Jr., Jacksonville (Duke 1954)
Huntley, Earl Stuart Jr., Miami (Maryland 1953)
Isham, Robert Lind, New Haven, Conn. (Duke 1949)
Isom, John Burnace, Nashville, Tenn. (Vanderbilt 1954)
Jacobs, Irwin Seymour, Miami (Jefferson 1953)
Johns, Thomas Nelson Page, Richmond, Va. (Johns Hopkins 1946)
Johnson, Edwin Aloysius (Col.), Clewiston (Col. P & S, Boston 1948)
Johnson, Kenneth Samuel Jr., Sebring (Tulane 1954)
Johnson, Melvin Julius Jr., Chattanooga, Tenn. (Tufts 1945)
Jordan, Harry, Forsyth, Ga. (Georgia 1953)
Kahn, Charles Jules, Jacksonville (Tulane 1950)
Kaiser, Herbert Stanley, Coral Gables (Chicago 1953)
Kaupe, Arthur Peter, Palm Beach (Hahnemann 1947)
Kibler, Gordon Eugene, Toledo, Ohio (Western Reserve 1953)
King, Hueston Clark, Miami (Columbia 1954)



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Kirkland, Robert Graham, Coral Gables (Emory 1954)
Klippel, Allen Pummill, St. Louis (St. Louis 1946)
Knotts, Benjamin Franklin Jr., Plant City (Maryland 1954)
Krauss, Maurice Daniel, Brooklyn (Jefferson 1931)
Kupferberg, Julius Donald, New York (Canada 1939)

LaRue, Roger Pierre, Miami (Albany 1953)
Lawson, Robert Barrett, Miami (Harvard 1936)
Lay, William Randall, Miami (Vanderbilt 1943)
Lehman, David J. Jr., Newark, N. J. (Virginia 1939)
Leslie, Samuel Peter, Jamaica, N. Y. (New York U. 1937)
Levin, Herbert J., Baltimore (Maryland 1954)
Levy, David Hyman, Youngstown, Ohio (Indiana 1934)
Lewis, Austin Philip, Miami Springs (Rush Med. Col. 1929)
Link, Robert Jeffrey, St. Petersburg (Duke 1953)
Linn, Marion Joanne Lovell, New Smyrna Beach (Vanderbilt 1950)
Linn, Robert Joseph, New Smyrna Beach (Vanderbilt 1950)
Lowe, Edward Stewart, Jacksonville (Colorado 1929)

MacCordy, Cunningham Ramsey, Key West (Tulane 1948)
McComas, Ralph Wilson, Orange Springs (Tulane 1937)
McConnell, Ben Harrison Jr., Beltsville, Md. (Georgetown 1950)
McCumber, Myron Leroy, Miami (Medical Evangelists 1953)
McDowell, Edwin Hardy Jr., Emory University, Ga. (Emory 1954)
McKeithen, Walter Shands Jr., Jacksonville (Vanderbilt 1954)
Machle, Willard Frank Jr., Miami (Geo. Washington 1954)
Madry, John Gray Jr., Atlanta, Ga. (Georgia 1954)
Mangone, Edith Katherine, Jersey City, N. J. (Med. Col. Virginia 1941)
Manrodt, Spencer Chilton, Gainesville (Rochester 1952)
Masciocchi, Thomas Anthony, Orange, N. J. (Rush Med. Col. 1938)
Meleney, Frank Lamont, New York (Columbia 1916)
Meriwether, Richard Bennett, Birmingham, Ala. (Virginia 1951)
Meyer, Patricia Ann, Miami (Buffalo 1950)
Miller, Richard Jasper Jr., Tampa (Northwestern 1947)
Millstein, Gerald Jay, Lawrence, N. Y. (New York U. 1953)
Monnin, Charles Alfred Jr., Coral Gables (Switzerland 1950)
Monsour, Faris Solomon Jr., Richmond, Va. (Georgetown 1952)
Montgomery, Wayne Odell, Lakeland (Indiana 1953)
Monyek, Milton Sonniel, Hollywood (Middlesex 1939)
Moody, William Dean, Crystal Beach (Emory 1954)
Morrison, Charles Wilson, Key West (Med. Col. South Carolina 1919)
Mosco, James Arthur, Miami (St. Louis 1937)
Moseley, Arthur Jefferson Jr., Augusta, Ga. (Emory 1947)
Murphy, Frank Patrick, Tampa (Loyola 1954)
Murphy, John Daily, Fort Lauderdale (Maryland 1954)
Myhree, Earl Peter, St. Petersburg (Temple 1945)

Needell, Elaine, Buffalo (Hahnemann 1950)
Needell, Mervin Harvey, Buffalo (Hahnemann 1950)



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Nestor, John Oliver, Arlington, Va. (Georgetown 1940)
Nichols, John Alan, Miami Beach (Vanderbilt 1948)
Nonkin, Paul Martin, Miami (New York Med. Col. 1954)
Noyes, Charles Evans Jr., Orlando (Hahnemann 1953)

Owen, William Spurlock, St. Petersburg (Emory 1954)

Pallas, William Charles, Portsmouth, Va. (Long Island Col. Med. 1944)
Palmer, Robert Conrad Jr., New Orleans (Tulane 1954)
Paxton, George Bernard Jr., Jacksonville (Tulane 1953)
Payne, Voris Ralph, St. Petersburg (St. Louis 1940)
Pearl, Morton, Miami Beach (Jefferson 1936)
Penick, Richard Quentin, Harrisonburg, Va. (Med. Col. Virginia 1948)
Pennington, Townsend Sanders, Lake Wales (Emory 1954)
Pfeifer, Robert Henry, Birmingham, Ala. (Northwestern 1942)
Pierleoni, Ermete Ernest, Hialeah (Rochester 1951)
Ploss, William Roger, Miami (Buffalo 1949)
Pollock, Adrian Quillian, Fort Myers (Emory 1954)
Potanos, John Nicholas, East Meadow, Long Island, N. Y. (Temple 1951)
Pound, Edwin Currier, Atlanta, Ga. (Emory 1954)
Prevatt, Amos Lee, Tampa (Tulane 1954)

Radkins, Laurent Vincent Jr., Chicago (Chicago 1952)
Rast, Charles Lewis Jr., Durham, N. C. (Johns Hopkins 1947)
Raulston, Jack Hunter, Boynton Beach (Georgia 1953)
Reid, James Robert Jr., Key West (Med. Col. South Carolina 1930)
Reinartz, Paul Victor, Jacksonville (Pennsylvania 1926)
Reiswig, Richard Veon, Lower Lake, Calif. (Medical Evangelists 1948)
Rengarts, Robert Theodore, Orlando (Germany 1947)
Richardson, Charles Wellington, St. Petersburg (Med. Col. Virginia 1953)
Roberts, Charles McWhorter, Haines City (Tulane 1953)
Rogers, Bealer Theron Jr., Tallahassee (Emory 1954)
Rubitsky, Hyman Jacob, Coral Gables (Tufts 1947)
Rudolph, Burton Merle, Miami Beach (Jefferson 1953)

Samuels, Arthur Seymour, St. Petersburg (Tulane 1953)
Sanchez, Alex Francis, Plant City (Emory 1953)
Schoenberger, James Alan, Glen Ellyn, Ill. (Chicago 1943)
Servis, Lionel Theodore, Milwaukee (Marquette 1941)
Shekter, William Bernard, Coral Gables (New York U. 1950)
Sherman, Arthur Golden, Winter Haven (Harvard 1953)
Sherman, Roger Davis, Warrington (New York Med. Col. 1940)
Shifrin, Richard Glenn, Fort Leonard Wood, Mo. (Illinois 1950)
Shingleton, William Warner, Durham, N. C. (Bowman Gray 1943)
Shoemaker, Norman Clifford, Silver Spring, Md. (Nebraska 1933)
Sidransky, Herschel, Pensacola (Tulane 1953)
Silver, Marvin, Lake Worth (Vanderbilt 1947)
Silverman, Leonard Marvin, Miami Beach (Yale 1954)
Sindell, Harlan Wayne, Chicago (Tulane 1954)
Singer, Robert Louis, Chicago (Illinois 1954)
Snow, Selig David, Miami Beach (Chicago Med. Sch. 1952)
Soller, Alex, Miami (Wayne 1953)
Sommerfield, William Ansel, Sarasota (Western Reserve 1931)
Spaulding, Earl Milton, Pensacola (Louisville 1940)
Spear, Harold Charles, New Haven, Conn. (Harvard 1947)
Spence, Ranel Bivens, St. Petersburg (Tennessee 1953)

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Stanford, Walter Jackson, St. Petersburg (Med. Col. Virginia 1953)
Steele, Hugh Gene, Tampa (Tulane 1952)
Stevenson, Alan James, Tampa (Arkansas 1947)
Stickle, Arthur Waldo, Pensacola (Oklahoma 1943)
Stokes, Frank Curry, Fort Lauderdale (Louisville 1953)
Stromberg, William, Jacksonville (Col. P & S, Boston 1949)
Sullivan, James Jerry, Tampa (Indiana 1953)
Sweany, Henry C., Tampa (Rush Med. Col. 1921)
Sweimler, Myrtle, Seffner (Rush Med. Col. 1929)

Takos, Michael James, Hialeah (Michigan 1951)
Tanner, Terry Finley, St. Petersburg (Med. Col. Virginia 1953)
Taylor, Charles Edgar, Sarasota (Northwestern 1953)
Taylor, Coleman, Tampa (Emory 1954)
Teborek, Roy Frank, Berwyn, Ill. (Illinois 1938)
Thames, Rufus, Jacksonville (Maryland 1954)
Theodore, Frederick Harold, New York (Columbia 1931)
Thomley, Miles Wesley, Orlando (Wisconsin 1941)
Thompson, John Morgan, Tampa (Johns Hopkins 1948)
Tirsch, Harry, Coral Gables (Long Island Col. Med. 1921)
Tobias, James Brickles, Fremont, Ohio (Harvard 1944)
Tourney, Garfield, Miami (Illinois 1948)
Tsagaris, Theofilos John, St. Augustine (Emory 1954)
Tumarkin, Bernard, Charleston, S. C. (Chicago Med Sch. 1944)
Turner, Wilbur Sanford, Charlottesville, Va. (Buffalo 1948)

Ullman, Albert Fisher, Panama City (Columbia 1946)
Unger, Pat Benjamin, Miami (Emory 1954)
Upshaw, Charles Bell Jr., Atlanta, Ga. (Emory 1954)
Uricchio, Joseph Francis, Camden, N. J. (Tufts 1949)

Valin, Jack Louis, Fort Lauderdale (Cincinnati 1937)
Vandever, Harry Wallace, Rochester, Minn. (Tennessee 1948)
von Storch, Theodore Joseph Constant, Miami (Johns Hopkins 1931)

Wagner, Glen, Miami (Ohio State 1953)
Walker, Robert Toovey, Aberdeen, Md. (Cincinnati 1949)
Walker, William Harold, Panama City (Cornell 1944)
Ward, Harold Wayne, Charlottesville, Va. (Med. Col. Virginia 1935)
Warren, Lyman Otis, St. Petersburg (Harvard 1941)
Warson, Samuel Russell, Sarasota (Canada 1934)
Watson, Ernest Starr, Elmhurst, Ill. (Rush Med. Col. 1928)
Webster, Bruce Stuart, Atlanta, Ga. (Vanderbilt 1954)
Webster, Robert Nelson, Jacksonville (Washington 1946)
Weible, David Murry, Fort Walton Beach (Washington 1950)
Welsh, Russell Leo, Daytona Beach (St. Louis 1950)
Wemple, Jay Nevin, Coral Gables (Med. Col. Virginia 1950)
West, James Lee Jr., St. Petersburg (Louisiana State 1948)
Williams, Frank Edward, Century (Hahnemann 1952)
Willis, William Russell, Orlando (Emory 1943)
Wolfson, Sorrell Louis, Tampa (Vanderbilt 1954)
Worley, Lee McBride II, Nashville, Tenn. (Vanderbilt 1954)

Yoffee, Harry Frank, Jacksonville (Tulane 1954)
Youmans, Julian Ray, Baxley, Ga. (Emory 1952)
Young, Ulysses Alexander, Tampa (Baylor 1948)

Zaydon, Thomas John, Miami (Hahnemann 1944)

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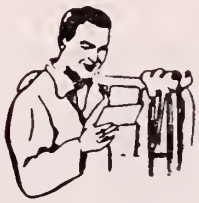
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Mix the same foods many ways—

Strained chicken in milk makes "bisque"—in tomato juice it's "creole." Strained liver and bacon double-times the same way.

Your patient may like cottage cheese whipped int milk flavored with chocolate and mint, or he can blend it with cranberry juice sparked with lime.

Strained carrots go in milk, broth, or pineapple juice. Flavor the milk blend with nutmeg, the broth with parsley, and the juice with cinnamon and brown sugar. An egg or skim milk powder may be added for a protein bonus.

Strained fruits in fruit juices do well with a squeeze of lemon or a touch of mint.

Then serve them up with dash—

Bright colored drinks look good in clear glass—pale ones in gayly painted glasses. And if a mixture looks drab, hide it in a bean pot or a round jam jar wrapped in a napkin.

Add a bright plastic straw. And for garnish, try a sprinkle of spice, a spoonful of sherbet, a dab of whipped cream, or a lemon slice hooked on the edge of the glass. Or frost the rim by dipping the glass in water, then in sugar.

Of course, only you can tell your patient *just which foods* he can and must have for his specific condition. But these suggestions can help guide him within the limits you set.

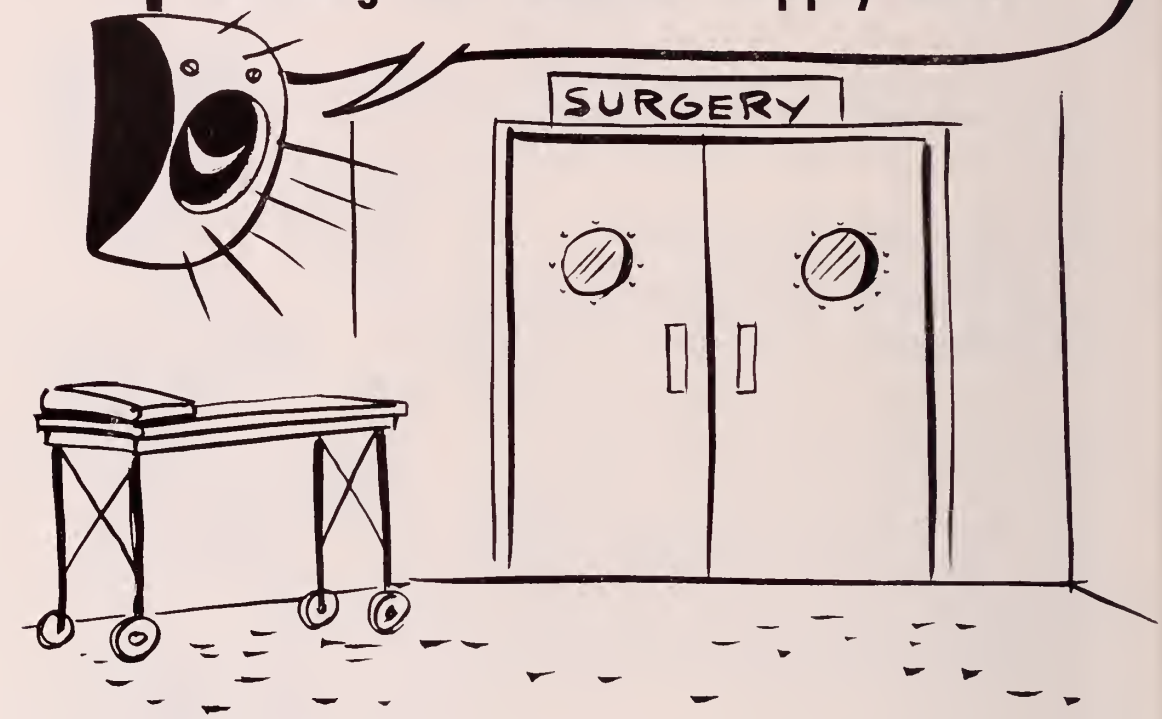
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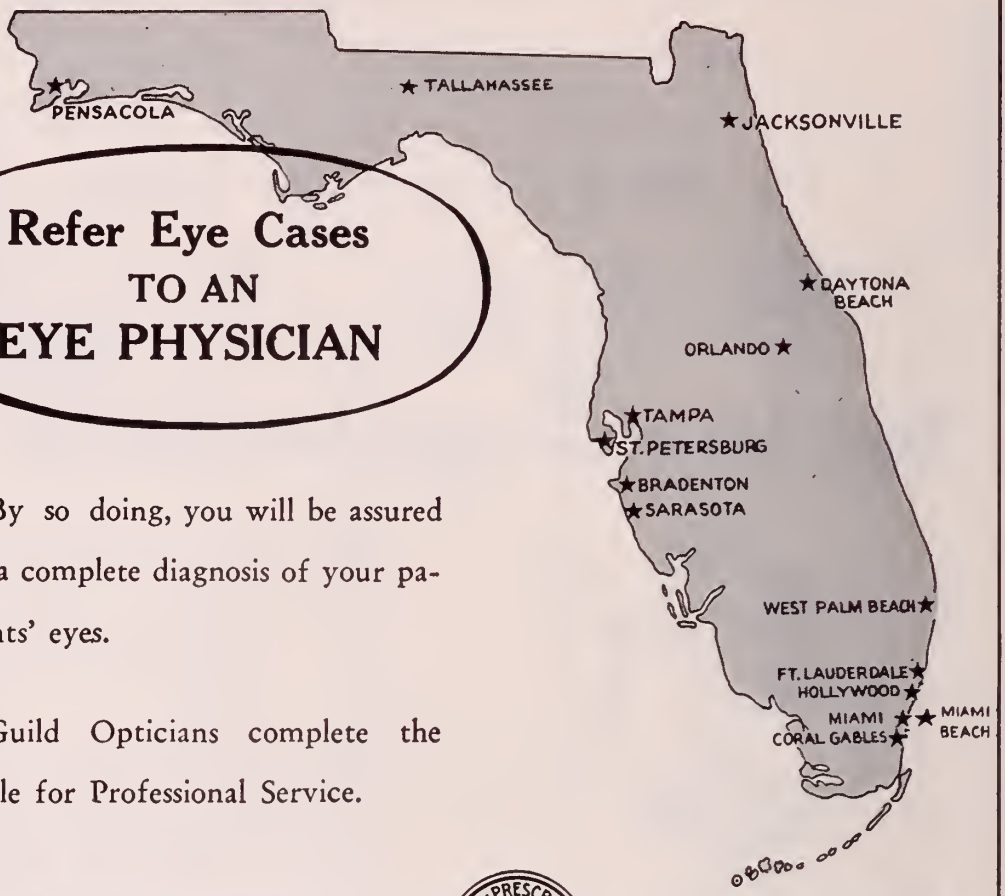
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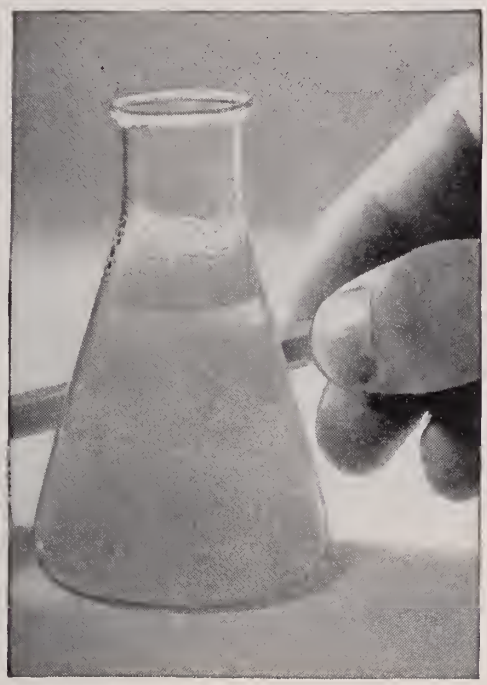
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"... the use of added acid buffers is not required for oral administration; ... because of the limited solubility of benzathine penicillin G [BICILLIN] *in the stomach, it is not highly susceptible to destruction by gastric juices."*[1]

After ½ hour in artificial gastric juice (pH 1.6), BICILLIN remains relatively insoluble, and is nearly 75% active. (BICILLIN used at a concentration of 2000 units per ml., approximating the antibiotic concentration in the stomach after a dose of 300,000 units.)

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1. *American Medical Association: New and Nonofficial Remedies, 1954. J. B. Lippincott Co., Philadelphia, p. 147*
2. *Scott, R. L., and others: Antibiot. & Chemo. 4:691 (June) 1954*

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> In continuing and repeated impartial scientific tests, KENT's Micronite Filter consistently proves that it takes out *more* nicotine and tars than *any* other filter cigarette, old or new.

And yet, with all its superior protection, KENT's Micronite Filter lets smokers enjoy the full, satisfying flavor of fine, mellow tobaccos.

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Kent

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The effectiveness and notable safety of Veriloid (the original alkavervir fraction of Veratrum viride) make it particularly well suited for combination therapy in moderate to severe essential hypertension. The antihypertensive action of Veriloid is potentiated when the drug is used with other agents;[1,2,3,4] hence smaller dosage of each, Veriloid and the comedication, yields a combined effect more potent than either drug alone when used in full dosage.[1,2,4]

Veriloid may be combined with sedative agents, with hydralazine, or with hexamethonium, resulting in lower dosages required for each.

Says a recent report[4] regarding the concomitant use of Veriloid with hydralazine: "In a few cases the addition of Veriloid permitted the use of a smaller dose of Apresoline. In other cases, after the addition of Veriloid, more hydralazine could be used with a resultant improvement in blood pressure response. There were [5] instances where...the blood pressure was lowered beyond that obtained with the latter drug alone."

Veriloid is supplied in 2 mg. and 3 mg. slow-dissolving scored tablets. When used as sole medication, initial daily dosage is 8 or 9 mg. in divided doses, not less than 4 hours apart, preferably after meals.

When used in combination with other antihypertensive drugs, the dosage of Veriloid may be reduced by as much as 50%.[1]

1. Allen, E.V.; Barker, N.W.; Hines, E.A., Jr.; Kvale, W.F.; Shick, R.M.; Gifford, R.W., Jr., and Estes, J.E., Jr.; Proc., Staff Meet. Mayo Clin. *29*:459 (Aug. 25) 1954.
2. Livesay, W.R.; Moyer, J.H., and Miller, S.I.: J.A.M.A. *155*:1027 (July 17) 1954.
3. Wilkins, R.W.: Mississippi Doctor *30*:359 (Apr.) 1953.
4. Kert, M.J.; Rosenfeld, S.; Mailman, R.H.; Westergart, J.P.; Carleton, H.G., and Hiscock, E.: Angiology *5*:318 (Aug.) 1954.

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IN A NEW and engaging book, the history of the medical uses of wine has been traced in scholarly fashion from biblical times to the present.*

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Wine—to Stimulate Appetite, Aid Digestion—We know now why wine plays such a valuable role as a stimulant to appetite in the anorexia of old age or convalescence. Two to three ounces of dry table wine have been found to markedly increase olfactory acuity.

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The Flavorsome Fine Wines of California—The fine wines of California are delicious, and the variety is so wide that a wine can be found to suit each taste.

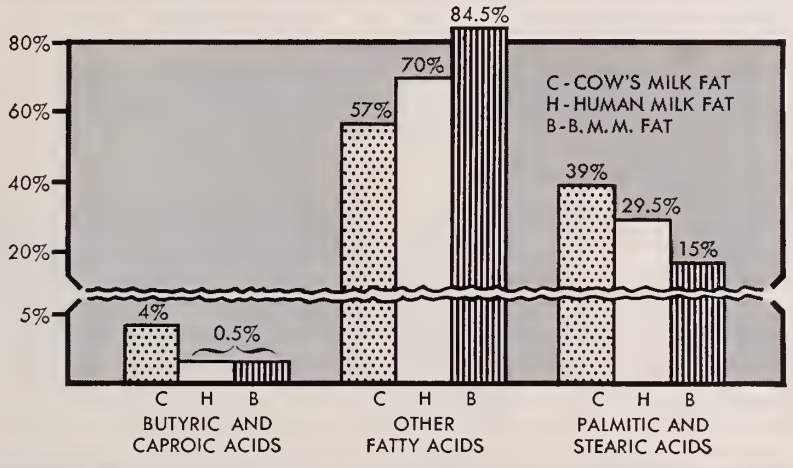
Here in the land of rich soils and sunshine, each grape variety comes to perfect ripeness under ideal conditions—and the high quality standards of California wines are controlled by modern scientific methods. There's Port, Sherry, Muscatel, Burgundy, Sauterne, Zinfandel, Rhine Wine, all at reasonable prices. Wine Advisory Board, 717 Market Street, San Francisco 3, California.

*Lucia, S. P.: Wine as Food and Medicine, New York, The Blakiston Company, Inc., 1954.

**Research information on wine is available upon request.

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Meat...

and Its Contribution to Fat Needs

Fat, the most concentrated source of nutrient energy, constitutes a dietary essential in human nutrition.[1] It is needed in growth and replacement of tissues, for specific lipid secretions, and for providing physiologic energy.[1,2] Absorbed fatty acids may be incorporated into more complex lipids, deposited in adipose tissue, converted into other fatty acids, used in production of milk fat, transformed into glucose or glycogen, or oxidized to carbon dioxide and water with liberation of energy.[3]

Evidence indicates that long continued extremely low fat intake in adults is incompatible with good health.[4,a] In addition to protecting tissue protein against catabolism for energy needs (the protein-sparing action of fat), sufficient amounts of fat in the dietary promote storage of protein.[4,b] In a normal mixed diet, fat is about 95 per cent as efficient as carbohydrate for production of muscular work.[4,c]

Neither the optimal level of fat in the diet nor the optimal range for apportionment of fat and carbohydrate to meet calorie allowances is known.[1,2]

Contrary to general impressions, fat in the mixed diet is effectively digested.[4,d] In moderate amounts it does not appreciably influence the digestibility of other foods.[5] Fat enhances the satiety value of meals, and foods naturally containing fat and those prepared with fat add much to the flavor value of meals. High fat diets sometimes are useful in alleviating constipation.[6]

Meat, according to its kind and cut, provides variable amounts of fat which contribute importantly to the body's need for fat. The fat of meat is almost completely digested. Meat also supplies valuable amounts of high biologic quality protein, B vitamins, and essential minerals. Skeletal muscle meat contains less than 0.1 per cent of cholesterol.[7]

---

1. Goldsmith, G. A.: Application to Human Nutrition, in Bourne, G. H., and Kidder, G. W.: Biochemistry and Physiology of Nutrition, New York, Academic Press Inc., 1953, chap. 23, p. 505.
2. Recommended Dietary Allowances, Washington, D. C., National Academy of Sciences—National Research Council, Publication 302, 1953, p. 23.
3. Ekstein, H. C.: Fat in Nutrition, in Handbook of Nutrition, A Symposium, ed. 2, Philadelphia, The Blakiston Company, 1951, p. 23.
4. Sherman, H. C.: Chemistry of Food and Nutrition, ed. 8, New York, The Macmillan Company, 1952, (a) p. 30; (b) p. 198; (c) p. 115; (d) p. 103.
5. McLester, J. S., and Darby, W. J.: Nutrition and Diet in Health and Disease, ed. 6, Philadelphia, W. B. Saunders Company, 1952, pp. 130-135.
6. Smith, F. H.: The Use of High Fat Diets for Constipation, J.A.M.A. *88*:628 (Feb. 26) 1927.
7. Okey, R.: Cholesterol Content of Foods, J. Am. Dietet. A. *21*:341 (June) 1945.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



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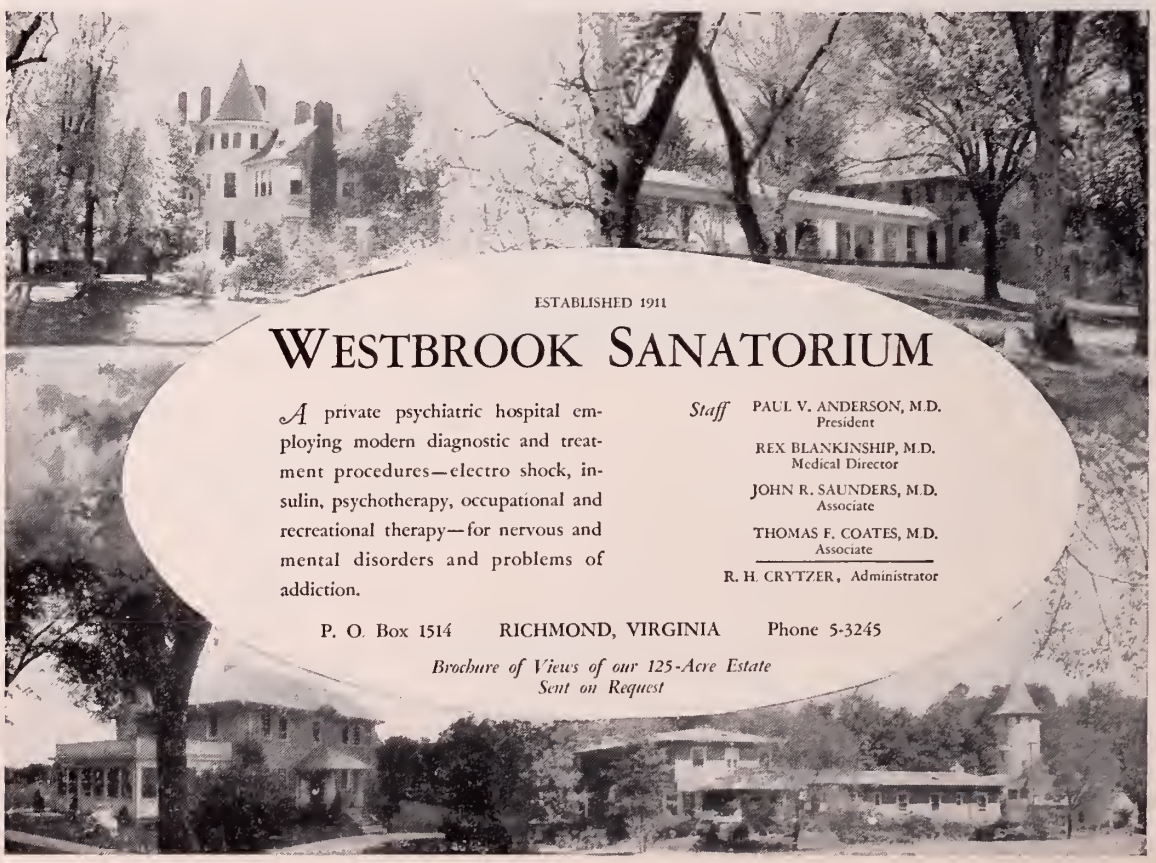
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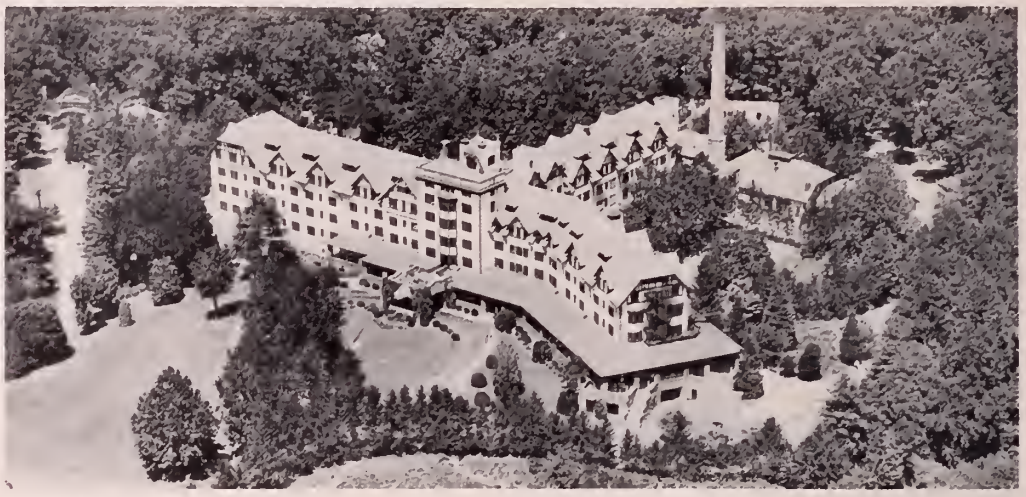
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
a Medical Association	Duncan T. McEwan, Orlando	Samuel M. Day, Jacksonville	St. Petersburg, Apr. 3-6, '55
a Medical Districts	Francis H. Langley, St. Petersburg	Council Chairman	
orthwest	William H. Hixon, Pensacola	George S. Palmer, Tallahassee	Pensacola
ortheast	Henry J. Babers Jr., Gainesville	Thomas C. Kenaston, Cocoa	Gainesville
outhwest	Clyde O. Anderson, St. Petersburg	James R. Boulware Jr., Lakeland	Lakeland
outheast	James R. Sory, West Palm Beach	Russell B. Carson, Ft. Lauderdale	Fort Lauderdale
a Specialty Societies			
ay of General Practice	Leonard L. Weil, Miami Beach	Leon S. Eisenman, Hialeah	St. Petersburg, Apr. 3, '55
Society	Solomon D. Klotz, Orlando	Edwin P. Preston, Miami	" "
esiologists, Soc. of	R. Gaylord Lewis, West Palm Beach	Harry E. Bierley, West Palm Beach	" "
Phys., Am. Coll., Fla. Chap.	DeWitt C. Daughtry, Miami	Jack Reiss, Coral Gables	" "
and Syph., Assn. of	Hollis F. Garrard, Miami	Joseph A. J. Farrington, Jacksonville	" "
Officers' Society	Thomas E. Morgan, Jacksonville	Lorenzo L. Parks, Jacksonville	" "
rial and Railway Surgeons	Plumer J. Manson, Miami	John H. Mitchell, Jacksonville	" "
logy & Psychiatry	Sullivan G. Bedell, Jacksonville	Roger E. Phillips, Orlando	" "
d Gynec. Society	Harold G. Nix,Tampa	Reuben B. Chrisman Jr., Miami	" "
al. & Otol., Soc. of	G. Tayloe Gwathmey, Orlando	Carl S. McLemore, Orlando	" "
edic Society	John F. Lovejoy, Jacksonville	Newton C. McCollough, Orlando	" "
ogists, Society of	Millard B. White, Sarasota	James B. Leonard, Tampa	" "
ric Society	C. Jennings Derrick, W. Palm Bch.	Wesley S. Nock, Coral Gables	
logic Society	Claude G. Mentzer, Miami	George Williams Jr., Miami	St. Petersburg, Apr. 3, '55
logical Society	A. Judson Graves, Jacksonville	James T. Shelden, Lakeland	" "
ns, Am. Coll., Fla. Chapter	Frederick J. Waas, Jacksonville	C. Frank Chunn, Tampa	" "
ical Society	Linus W. Hewit, Tampa	Frank J. Pyle, Orlando	" "
a—			
c Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, Nov. 6, '54
d Banks, Association	John T. Stage, Jacksonville	John B. Ross, Jacksonville	St. Petersburg, 1955
Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	Palm Beach Shores, Nov. 17, '54
Shield of Florida, Inc.	David R. Murphey Jr., Tampa	Jack O. W. Rash, Miami	
cer Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	St. Petersburg, Apr. 3, '55
ical Diabetes Assn.	Fred Mathers, Orlando	Edward R. Smith, Jacksonville	
tal Society, State	Robt. Thoburn, D.D.S., Daytona Bch	J. E. Edwards, D.D.S., Coral Gables	Jacksonville, Apr. 23-25, '55
rt Association	Alvin E. Murphy, Palm Beach	Daniel R. Usdin, Jacksonville	April 1955
pital Association	Mr. J. F. Wymer Jr., W. Palm B.	Mrs. Mary Reeder, Miami	Palm Beach Shores, Nov. 18-19, '54
lical Examining Board	Frank D. Gray, Orlando	Homer L. Pearson Jr., Miami	Jacksonville, Nov. 21-23, '54
lical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
se Anesthetists, Fla. Assn.	Miss Dorothy Jackson, C. Gables	Mrs. Lulla F. Bryan, Miami	Palm Bch. Shores, Nov. 17-19, '54
ses Association, State	Mrs. Bertha King, Tampa	Mrs. Idalyn Lawthon, Tampa	
rmaceutical Association, State	Mr. J. L. McDonald, St. Augustine	Mr. R. Q. Richards, Ft. Myers	Clearwater, May '55
lic Health Association	Frank M. Hall, Gainesville	Mr. Fred B. Ragland, Jacksonville	
deau Society	Lawrence C. Manni, Tallahassee	Simon D. Doff, Jacksonville	May, 1955
erculosis & Health Assn.	Judge Ernest E. Mason, Pensacola	Mrs. L. C. Conant, Fort Myers	
nan's Auxiliary	Mrs. Richard F. Stover, Miami	Mrs. S. J. Wilson, Ft. Lauderdale	St. Petersburg, Apr. 3, '55
can Medical Association	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	Atlantic City, June 6-10, '55
I.A. Clinical Session	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	Miami, Nov. 29-Dec. 2, '54
ern Medical Association	Alphonse McMahon, St. Louis	Mr. C. P. Loranz, Birmingham	St. Louis, Nov. 8-11, '54
ma Medical Association	J. M. Donald, Birmingham	Douglas L. Cannon, Montgomery	Montgomery, Apr. 21-23, '55
ia, Medical Assn. of	Peter B. Wright, Augusta	David Henry Poer, Atlanta	Augusta, May 1-4, '55
Hospital Conference	Mr. John W. Gill, Vicksburg, Miss.	Mr. Pat Groner, Pensacola	Atlanta, Apr. 20-22, '55
eastern Allergy Assn.	W. L. Rucks, Memphis, Tenn.	Kath. B. MacInnis, Columbia, S. C.	Orlando, 1955
eastern, Am. Urological Assn.	Sam L. Raines, Memphis, Tenn.	Robert F. Sharp, New Orleans	New Orleans Mar. 20-23, '55
eastern Surgical Congress	J. Duffy Hancock, Louisville, Ky.	B. T. Beasley, Atlanta	Atlanta, Mar. 7-10, '55
Coast Clinical Society	Jas. N. Lockard, Pascagoula, Miss.	F. C. Minkler, Pascagoula, Miss.	

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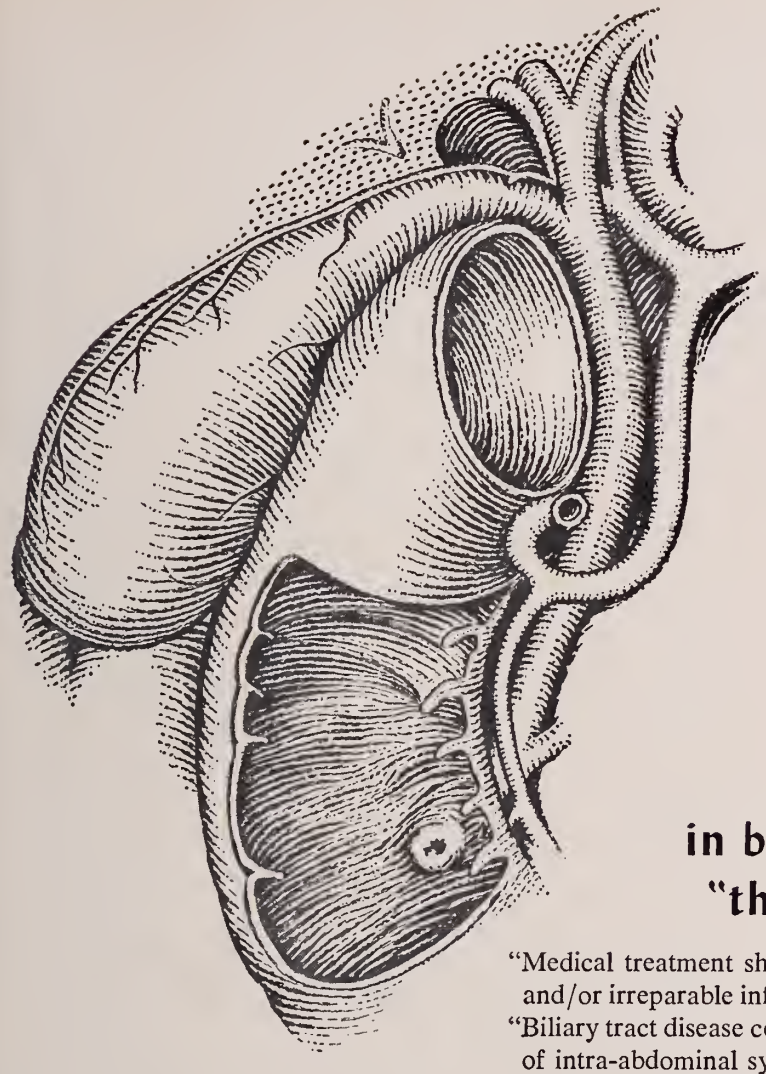
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County Medical Societies of Florida

SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Total Members
Alachua	Henry H. Graham, Gainesville	Glenn O. Summerlin, Gainesville	2nd Tues.	51
***Bradford, Gilchrist, Union**				
Bay	Lemuel F. Coxe Jr., Panama City	James D. Nixon, Panama City	1st Tues.	25
Brevard	Theodore J. Kaminski, Melbourne	Isabel Roberts, Melbourne Ho., Melbourne	2nd Tues.	28
Broward	Julius F. Boettner, Fort Lauderdale	George T. F. Rahilly, Fort Lauderdale	4th Tues.	111
Columbia	Robert B. Harkness, Lake City	Thomas H. Bates, Lake City	1st Mon.	12
***Baker, Hamilton**				
Dade	Edward W. Cullipher, Miami	Kenneth S. Whitmer, Miami	1st Tues.	673
DeSoto-Hardee-Highland-Glades	Carl J. Larsen, Avon Park	Samuel A. King, Avon Park	2nd Tues.	27
Duval	Karl B. Hanson, Jacksonville	Jackson L. Allgood Jr., Jacksonville	1st Tues.	274
***Clay**				
Escambia	Wilton E. Tugwell, Pensacola	Paul F. Baranco, Pensacola	2nd Tues.	102
***Santa Rosa**				
Franklin-Gulf	Albert L. Ward, Port St. Joe	Warren T. Weathington, Apalachicola	Last Wed.	9
Hillsborough	C. Frank Chunn, Tampa	Julien C. Pate Jr., Tampa	1st Tues.	181
Indian River	William L. Fitts 3rd, Vero Beach	Vernon L. Fromang, Vero Beach	2nd Tues.	10
Jackson-Calhoun	Jabe A. Breland, Marianna	Francis M. Watson, Marianna	Quarterly	17
Lake	J. Basil Hall, Tavares	James R. Hanson, Tavares	1st Wed.	29
***Sumter**				
Lee-Charlotte-Collier-Hendry	H. Quillian Jones, Fort Myers	James L. Bradley, Fort Myers	3rd Mon.	37
Leon-Gadsden-Liberty-Wakulla-Jefferson	George H. Massey, Quincy	Odis G. Kendrick Jr., Tallahassee	Quarterly	60
Madison	Wallace E. Winter, Madison	Julian M. DuRant, Madison		5
Manatee	Willett E. Wentzel, Bradenton	Marjorie L. Warner, Bradenton	2nd Tues.	25
Marion	William H. Anderson Jr., Ocala	Bertrand F. Drake, Dunnellon	3rd Tues.	30
***Levy**				
Monroe	Edward Gonzalez, Key West	Herman K. Moore, Key West	2nd Thurs.	12
Nassau	David G. Humphreys, Fernandina	John W. McClane, Fernandina	Last Fri.	11
Orange	Eugene L. Jewett, Orlando	Andrew W. Townes Jr., Orlando	3rd Wed.	181
***Osceola**				
Palm Beach	Thomas E. Daly, West Palm Beach	David A. Newman, Palm Beach	4th Mon.	136
Pasco-Hernando-Citrus	Frank Y. Robson, New Port Richey	W. Wardlaw Jones, Dade City	2nd Thurs.	18
Pinellas	Alvin L. Mills, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	215
Polk	Theodore C. Keramidas, Winter Haven	James T. Shelden, Lakeland	2nd Wed.	91
Putnam	Lawrence G. Hebel, Palatka	James A. Long Jr., Palatka	2nd Tues.	10
St. Johns	James J. DeVito, St. Augustine	Reuben J. Plant Jr., St. Augustine	3rd Tues.	19
St. Lucie-Okeechobee-Martin	Laurance D. Van Tilborg, Ft. Pierce	Adrian M. Sample, Fort Pierce	3rd Thurs.	22
Sarasota	Henry J. Vomacka, Sarasota	Lloyd J. Duest, Sarasota	2nd Tues.	53
Seminole	J. Clifford Boyce, Sanford	Terry Bird, Sanford	2nd Tues.	20
Suwannee	William P. Blackmon, Mayo	Hiram B. Curry, Jasper	1st Sat.	9
Taylor	George H. Warren, Perry	Walter J. Baker, Foley	Last Fri.	4
***Dixie, Lafayette**				
Volusia	Cleland D. Cochrane, Daytona Beach	Robert L. Miller, Daytona Beach	2nd Tues.	84
***Flagler**				
Walton-Okaloosa	Robert von P. Maxon, Fort Walton	Arthur G. Williams Jr., Valparaiso	3rd Thurs.	20
Washington-Holmes	Ralph H. Segrest, Bonifay	Bayllye W. Dalton, Chipley		6
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1. Segal, H.: Postgrad. Med. *13*:81, 1953. 2. O'Brien, G. F., and Schweitzer, I. L.: M. Clin. North America *37*:155, 1953. 3. Beckman, H.: Pharmacology in Clinical Practice, Philadelphia, W. B. Saunders Company, 1952, p. 361.

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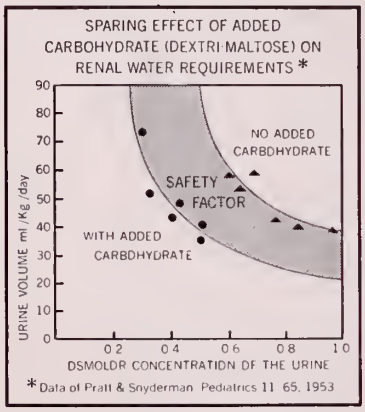
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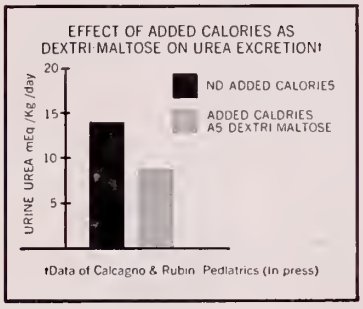
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1. Pratt & Snyderman: Pediatrics 11: 65, 1953; 2. Calcagno & Rubin: Pediatrics (in press); 3. Calcagno, Rubin & Weintraub: J. Clin. Investigation 33: 91, 1954; 4. Caake, Pratt & Darraw: Yale J. Biol. & Med. 22: 227, 1950; 5. Gamble: J. Pediat. 30: 488, 1947; 6. Rappaport: Am. J. Dis. Child. 74: 682, 1947.

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Vol. XLI DECEMBER, 1954 No. 6

Eighty-First Annual Meeting
St. Petersburg, April 3-6, 1955

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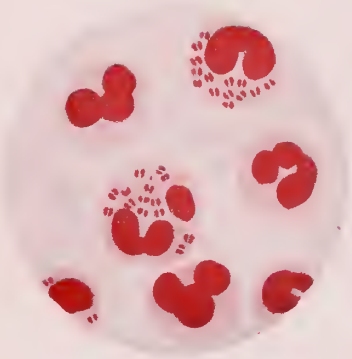
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(1) Yow, E. M.; Taylor, F. M.; Hirsch, J.; Frankel, R. A., & Carnes, H. E.: *J. Pediat.* **42**:151, 1953. (2) Dodd, K.: *J. Arkansas M. Soc.* **10**:174, 1954. (3) Hanbery, J. W.: *Neurology* **4**:301, 1954. (4) Miller, G.; Hansen, J. E., & Pollock, B. E.: *Am. Heart J.* **47**:453, 1954. (5) Keefer, C. S., in Smith, A., & Wermer, P. L.: Modern Treatment, New York, Paul B. Hoeber, Inc., 1953, p. 65.

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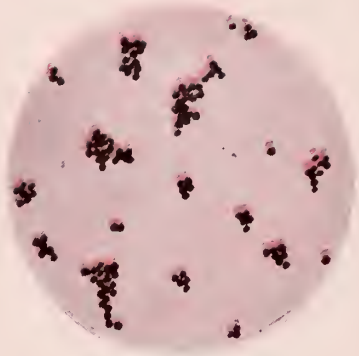
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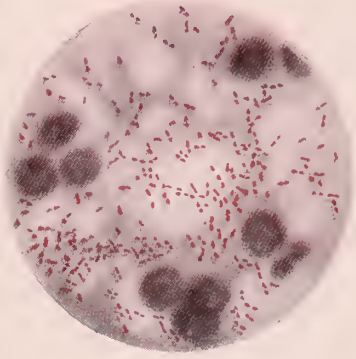
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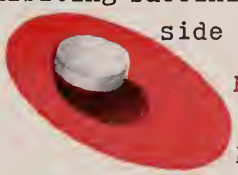


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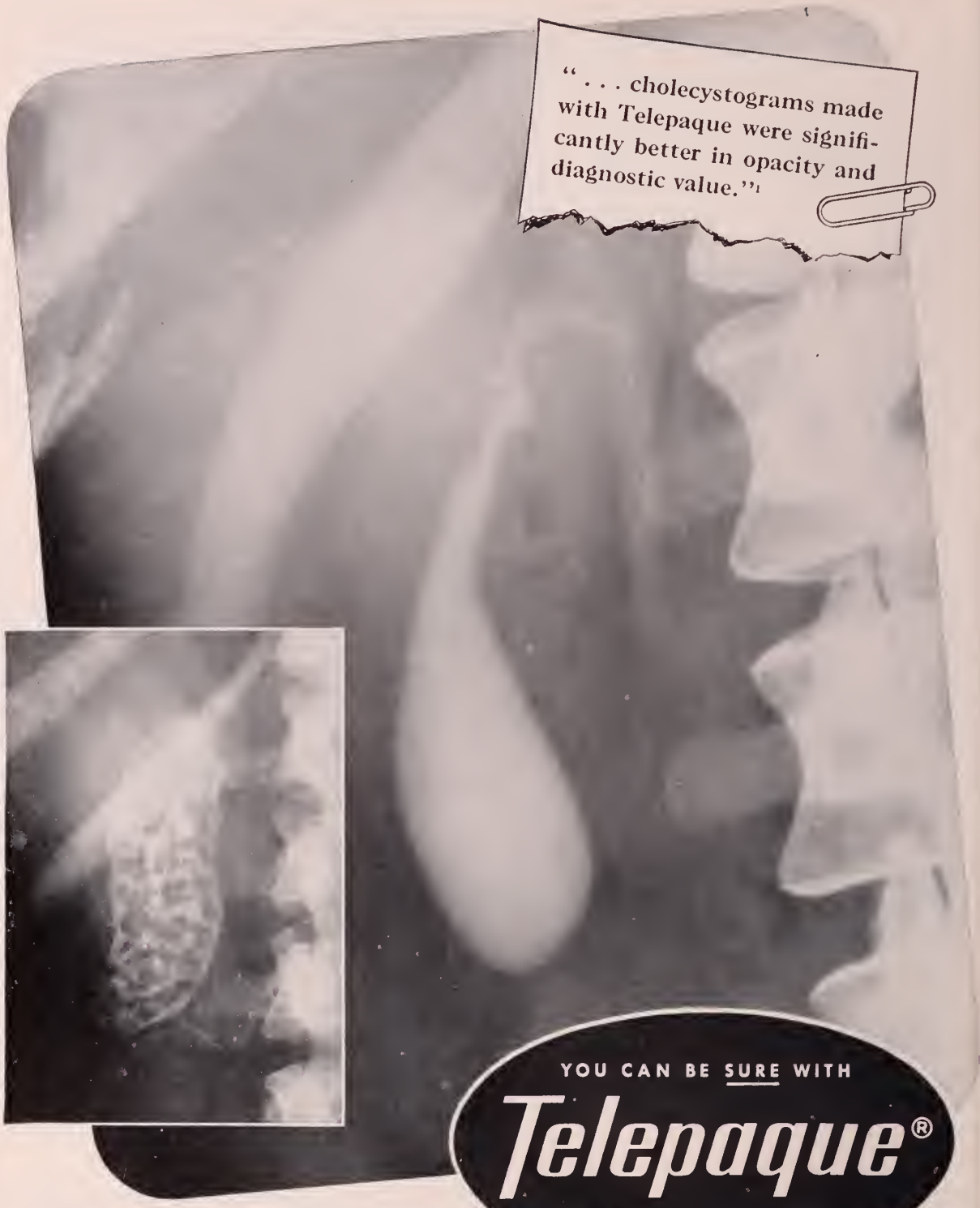
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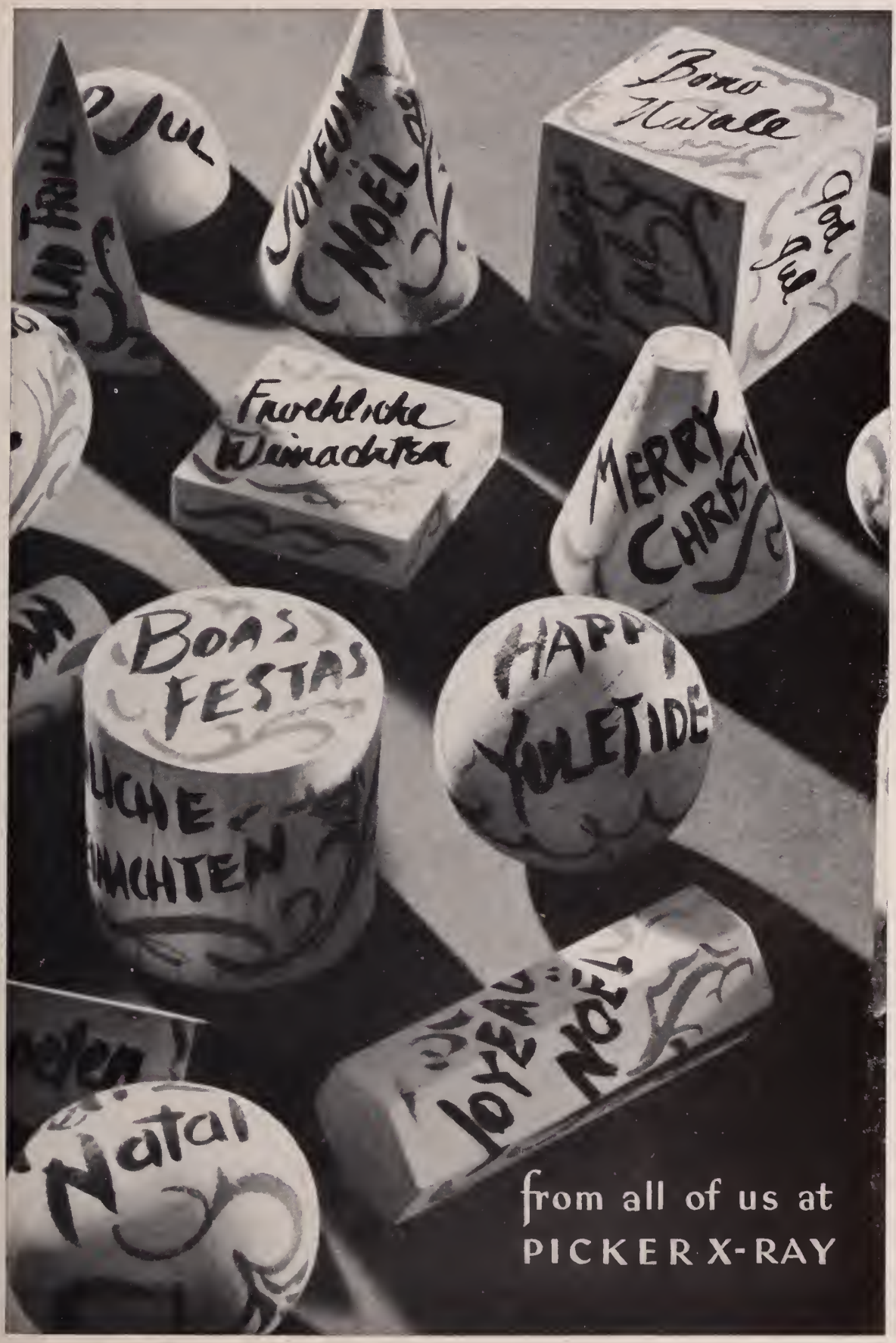
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1 Abel, M.S., Lomhoff, I.I., and Garcia, C.V.: *Permanente Found. Med. Bull.*, 10:95, Aug., 1952.
2 Lowman, R.M., and Stanley, H.W.: *Connecticut Med. Jour.*, 16:591, Aug., 1952.

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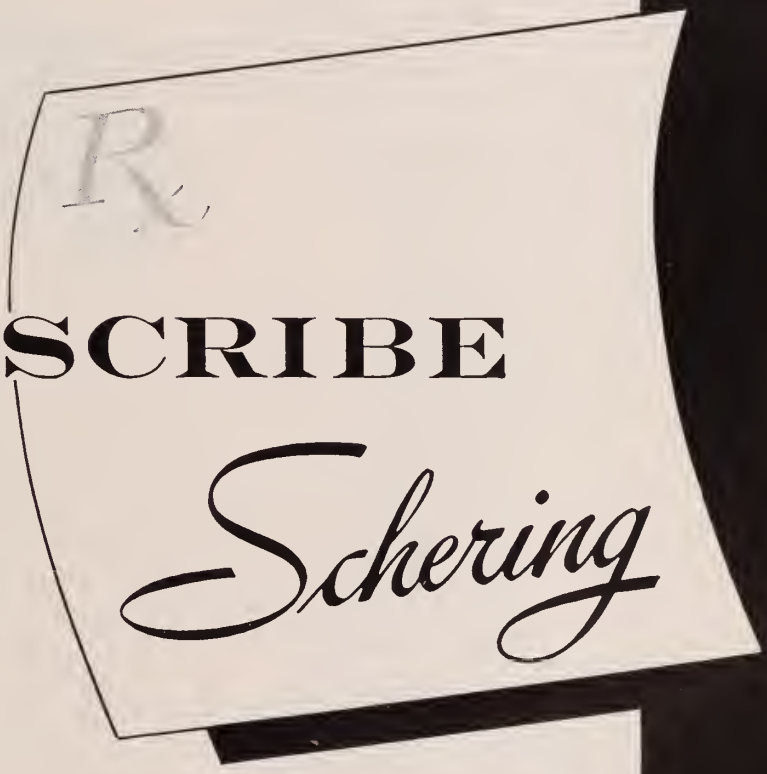
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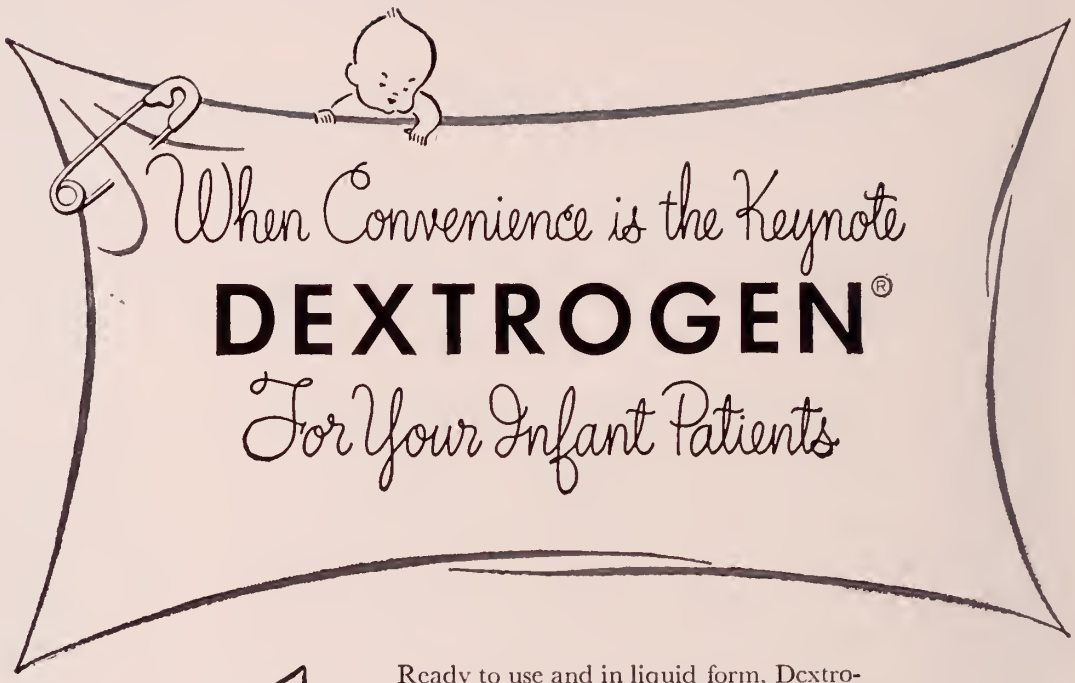
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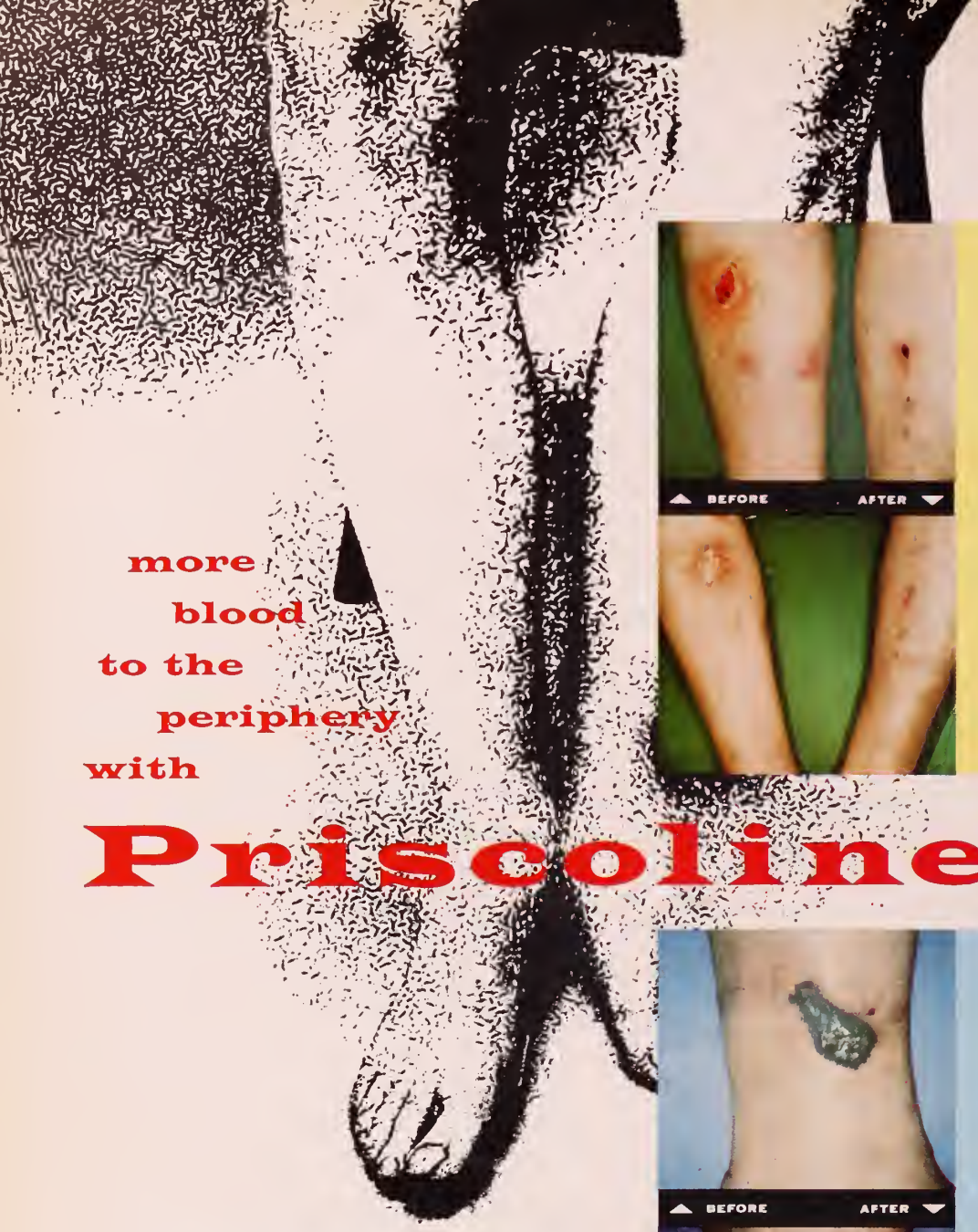
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1. Hollander, F.: Arch. Int. Med. *93:*107 (Jan.) 1954
2. Deutsch, E.: Scientific Exhibit, Gastroscopy, Clinical Meeting A.M.A., St. Louis, December, 1953

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1. Malleson, J.: Lancet 2:158 (July 25) 1953. 2. Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc. 1953, p. 23.

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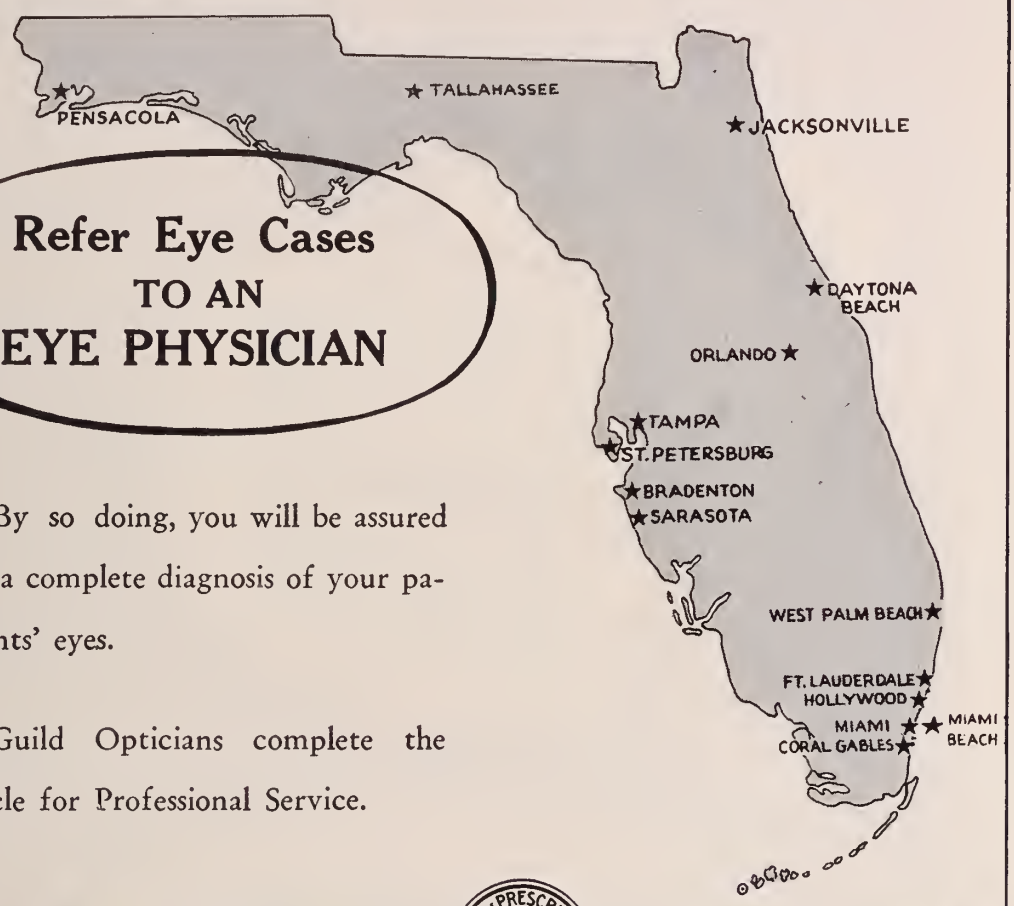
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Extensive Surgery and Repeated Surgery for Malignant Disease

SAMUEL M. DAY, M.D.
JACKSONVILLE

These are days in which the unknown may become the known tomorrow. Physicians of my vintage and before, and after for that matter, have seen changes in medicine and surgery that we can only term miraculous. We would have declared them impossible 20 years ago. Because of the possibilities of the uncertain becoming the certain and the unknown the known we doctors have a great responsibility.

Advancing longevity is bringing increasing numbers of cancer patients to us for care. Because of the nature of the disease as well as the reluctance of human beings to heed certain warning signs, we are encountering far too many of these patients late in the course of their disease. Fortunately, too, a considerable part of this delay may be caused by physicians who are still too prone to treat symptoms and not determine causes until pathologic conditions overwhelm us with their advancing severity.

Those of us practicing cancer surgery must retain an optimistic philosophy in dealing with patients, and we must be willing to go all out to give them the opportunity to "borrow time to live longer." We know not what is just around the corner for these hapless people — tomorrow may bring an "insulin" for a cancer; who knows?

Brunschwig,[1,2] Pack,[3-5] Lahey[6,7] and others have pioneered in the renewal of extensive resections in cancer surgery. This simply means a revision of the concepts of what constitutes "operability" or "inoperability." Statistically their results have not made the procedures "odds on favorites," but they have prolonged the life of many persons and a few have been, for all essential purposes, cured. All of us now realize that a patient being alive and well five years from the time of treatment does not insure a cure. Because "cures" are uncertain, palliation becomes a relative matter. Much depends on the patient's state of mind and health during the added time. The work of these surgeons has been criticized by many and praised by few, but some of those few have been these cancer patients who have been given new hope for life, if not new life.

Over the country today many surgeons are performing these procedures, but there are a great many more who are capable of performing them, if only they will develop the philosophy to try. Such work means tiring, prolonged operative procedures; alert and vigorous preoperative and postoperative care; conscientious cooperation of auxiliary services, anesthesia, laboratory, radiology and nursing; and well trained, conscientious house staffs.

There are not enough major centers doing this work to care for the number of patients needing it. Any surgeon who undertakes cancer surgery should never let inadequacies on his part prevent him from doing what is best for the patient. Let him prepare himself for removing all visible tumor with a safe margin if it can be removed. If he is unwilling to do so, let him limit his work to other surgical fields. He must be ready to ignore his operative mortality rate when weighed against the possibility of a prolonged and relatively comfortable life. Operative mortality, however, need not be a prohibitive item. Sweet,[8] Pack,[9] and others now report acceptable mortality rates. The purpose of this presentation is to attempt to show that such surgery can be performed in good general hospitals by conscientious surgeons with reasonable expectancy of success. Such surgery does

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not necessarily mean a disabled patient. My total gastrectomies and esophagectomies are few, but practically all the patients have resumed their preoperative duties, have gained varying amounts of weight, but never to preoperative level, and have enjoyed life for most of their borrowed time.

This report represents a study of 100 laparotomies and thoracotomies in adults for major disease of the gastrointestinal tract excluding appendectomies, cholecystectomies and benign pelvic surgery. Fifty-six of these were for cancer. Thirty-two were extensive operations, 29 of which were for cancer. Five cases are presented in detail to illustrate the value of attempting to give help by surgery when no other method remains.

These cases show what can be done in a good general hospital with good nursing anesthesia supervised by a competent anesthesiologist only during the past nine months, and with the usual auxiliary services for a hospital of 250 beds in a city of 300,000 population. Most of the patients were private patients treated at St. Vincent's Hospital. All were under my direct care although approximately half of those in the 1947-1951 period were operated on in association with Dr. Frederick J. Waas, who was most understanding and patient in cooperating with me and counseling me. To him I owe a debt of gratitude.

Report of Cases

Case 1. — Mrs. N. St. J., a 50 year old white woman, had experienced inability to swallow solid food for four months and a loss of 6 pounds in weight, with reduction from 120 to 114 pounds. She had first noticed difficulty in swallowing coffee, then solids. She had drunk numerous milk shakes to prevent further loss in weight. A nonsmoker, she had had a slight nonproductive cough. Since having jaundice some 10 years previously, she had had recurrent attacks of pain at intervals in the right upper quadrant of the abdomen, which she attributed to attacks of disease of the gallbladder, although they were precipitated by no particular food. She had always been underweight.

Her father died of "paralyzed throat" at 65 — a slow death because of inability to swallow. The mother died of "uremia" at 72 years of age.

The patient was an emaciated white woman, who appeared chronically ill. General examination yielded no evidence of pathologic change except a large rounded mass in the right upper quadrant of the abdomen, which moved on respiration and proved to be a displaced right kidney.

On examination of the blood, the red blood cell count was 4,260,000, the hemoglobin was 13.0 Gm., the white blood cell count was 7,800, and the serum protein was 6.3 Gm.

Roentgenograms, made by Dr. A. Judson Graves, gave evidence of an irregularity of the mid portion of the esophagus (fig. 1a). Esophagoscopy by Dr. G. Dekle Taylor revealed the presence of epidermoid carcinoma. This was confirmed by biopsy.

Thoracotomy on the left side through the bed of the sixth rib was performed on July 1, 1950. A single, large, hard lymph node was found anterior to the descending aorta, biopsy of which confirmed the presence of carcinoma. A large mass, 5 by 3 cm. in size, was found in the mid portion of the esophagus just below the aortic arch, located primarily on the posterior wall (fig. 1b). Although there were adhesions to the aorta, the esophagus and cardiac end of the stomach were freed and resected with all visible nodes from the peribronchial to the left gastric nodes, with none except the first one obviously involved. Esophagogastrostomy was then performed on the left of and approximately 1½ inches superior to the aortic arch. The apex of the closed stomach was used for the anastomosis. The esophagus was divided more than 5 cm. above the upper limits of the grossly involved tissue. The patient received 2,000 cc. of citrated blood while on the operating table. The pathologic diagnosis was epidermoid carcinoma, grade III.

The patient went into severe shock approximately eight hours postoperatively in spite of oxygen and general supportive measures. The administration of plasma and blood brought recovery. Oral liquids were started on the fourth postoperative day without difficulty. Thereafter the course was uneventful except for the usual digestive disturbances accompanying conditions of this kind. There was constipation, considerable fulness, particularly on lying down soon after meals, and further loss in weight. With frequent small feedings and vitamins, there was gradual improvement. In five weeks she had gained 1 pound and wanted more food than she could retain comfortably.

In March 1951, the patient experienced increasing dysphagia. Esophagoscopy by Dr. Taylor at this time revealed no tumor but slight stricture and esophagitis. Dilatation was not necessary. In July she felt better than at any time since her illness. In September she directed my attention to a supraclavicular mass on the left side, which had appeared one month previously and had enlarged rapidly. She had lost 2 pounds, reducing her weight to 100 pounds; otherwise she had no symptoms.

On October 3, a block dissection of the supraclavicular mass was carried out (fig. 1c). It measured approximately 5 by 4 by 3 cm. and was densely adherent, necessitating removal of the lower internal and external jugular and subclavian veins on the left side as well as the adjacent omohyoid and scalene muscles. The internal jugular vein was filled with an organizing thrombus without tumor infiltration. The mass proved to be a grade IV squamous cell carcinoma, metastatic, which was highly anaplastic and was infiltrating in all directions. The postoperative course was uneventful. The patient was given roentgen therapy by Dr. Floyd K. Hurt, 2,150 r through a 10 by 10 inch portal, and the induration of the area slowly subsided.

Since that time she has been checked at three month intervals with roentgen examination every six to nine months (fig. 1d). She feels well and is able to do the usual household and yard work that she did preoperatively. She eats anything she wants except fatty or greasy foods and travels as desired. Occasionally she has weakness and cold sweats and may have to lie down after eating. Her weight varies from 89 to 95 pounds, 25 to 30 pounds less than preoperatively. She has one normal-colored, constipated stool daily when she takes milk of magnesia. She no longer is disturbed by "gas," has been nauseated only once in the past year, and belches with difficulty. There is still slight supraclavicular induration on the left side, but no masses.

Of course the prognosis is still guarded, but almost four years have elapsed since the original operation, and two and one-half years since the excision of the supraclavicular metastases followed by roentgen therapy. Certainly the normal life she has led for that period of time justifies the radical procedures performed.

A second patient, with a similar lesion but without involvement of nodes, was subjected to esophagogastrectomy in January 1951. He communicated with me at irregular intervals, and I was recently notified of his death. On requesting further information from Kings County Hospital, Brooklyn, N. Y., in which he was followed as an

outpatient and finally died. I was informed that there was no evidence of recurrent cancer. He died of injuries sustained in a fall down the stairs at his home, which caused injury to the cervical spine and paralysis a few days before his death. Unfortunately, no autopsy was obtained.

nuclear leukocytes. Urinalysis gave normal results. He was given 1,500 cc. of whole blood. The blood protein was 5.2 Gm. on October 31.

Abdominal exploration on November 2 revealed a huge fungating adenocarcinoma, grade II, of the colloid type, 12 cm. in diameter (fig. 2a), occupying most of the anterior and lateral wall of the stomach with umbilication of the serosa and attachment of the omentum. The pylorus and first portion of the duodenum were fibrotic;



Fig. 1. Case 1.—(a)Lateral roentgenogram showing preoperative irregularity of mid esophagus. (b) Operative specimen, July 1, 1950. Squamous cell epithelioma of mid esophagus. (c) Operative specimen, Oct. 3, 1951. Squamous cell epithelioma in supraclavicular lymph nodes on the left side 15 months postoperatively. (d) Lateral roentgenogram showing postoperative esophagogastrostomy.

Case 2.—Mr. L. S., a 59 year old white man, was admitted to St. Vincent's Hospital for Dr. Frederick J. Waas and me on referral from Dr. Stanley Erwin on Oct. 29, 1949 because of recurrent severe hematemesis since Dec. 19, 1947. He had three severe bleeding episodes (December 1947, October 1948 and October 1949) during which multiple transfusions were necessary for the relief of shock and secondary anemia. He lost 10 pounds in weight. He experienced little abdominal discomfort and no related symptoms except those associated with the repeated hemorrhages. Diet and medications brought no change. On each admission he was treated with transfusions of whole blood and the Sippy diet with supplemental proteins, vitamins, liver extract and iron. He refused to consider surgery until the third episode of hematemesis because of the illness of his wife, due to squamous cell carcinoma of the rectum with metastases to the liver, and her subsequent death in May 1949.

The father was living and well at 90 years of age. The mother died of unknown cause. There was no history of cancer.

Except for gastroenterostomy for duodenal ulcer performed by Dr. Robert B. McIver in 1923, the history was irrelevant. Roentgen examination on Nov. 12, 1948 by Dr. Floyd K. Hurt suggested edema of the enterostomy stoma with small craters at the stoma which might have been responsible for the hemorrhage. No evidence of a pathologic condition in the stomach was noted, even on retrospect.

At the time of admission, the hemoglobin was 11.7 Gm. (70 per cent); red blood cells 3,490,000; white blood cells 15,050 with 90 per cent polymorphonuclear leukocytes; total protein 4.6 Gm. per hundred cubic centimeters with albumen 3.3 Gm.; and globulin 1.3 Gm. Urinalysis gave normal results.

The patient was discharged for 12 days to put his affairs in order and to attempt to improve his general condition by high protein, high carbohydrate diet with supplemental liver and vitamins. This proved valueless from a therapeutic standpoint.

When he was readmitted on November 10, the hemoglobin was 9 Gm. (66 per cent), red blood cells 3,430,000, and white blood cells 10,650 with 70 per cent polymorpho-

the gastroenterostomy site showed no evidence of ulceration or inflammation. Enlarged nodes were found in the gastrohepatic and the greater omentum. Diffuse adhesions were present. Total gastrectomy, omentectomy and splenectomy were performed. Biopsy of the ends of the resected esophagus and duodenum revealed no evidence of malignant disease. Though numerous nodes were enlarged, only one was found to contain metastatic carcinoma of similar type. A long loop end to side esophagojejunostomy was performed. The old gastroenterostomy stoma was excised, and that opening was used as one side of a jejunojejunostomy. During the procedure 2,500 cc. of blood was given.

The postoperative course was stormy. On the night following the operation, a tension pneumothorax developed and was relieved by aspiration of 2,800 cc. of air. Hemopneumothorax followed. Closed thoracotomy was performed with good results. Oral tap water and albumin water were started on the fifth postoperative day, and no difficulty was encountered. Soft foods were added on the eighth postoperative day. The patient was discharged from the hospital on November 26. He complained of mild dysphagia and gaseous eructation at that time. Fulness during and after meals was distressing. Despite anorexia, he ate what was put before him in five or six small meals daily. Bowel movements were regular.

His condition steadily improved. Within one month he was eating three meals daily and experiencing associated moderate epigastric fulness and frequent regurgitation of bile-stained fluid. It was necessary that he remain in the upright position for an hour or more after meals. In the spring of 1950 the regurgitation abated, and he was much better. He went through a period of great mental tension in the summer associated with his work and he again experienced extreme epigastric fulness and noted difficulty in swallowing. Roentgenograms in August gave evidence of moderate stricture at the esophagojejunal junction. He received an important judicial appointment that month, and there followed slight relief of symptoms. He lost 5 pounds in weight, and increasing dysphagia developed. In September it took him 45 to 60 minutes to eat a ham sandwich and drink a cup of coffee. Esophagoscopy was advised, but he refused because of an important court session.

He returned to Jacksonville by plane from Houston, Texas, in November 1950 with complete obstruction. Esophagoscopy by Dr. G. Dekle Taylor revealed recurrent adenocarcinoma at the site of anastomosis. His condition was explained to him in detail, and he was offered the opportunity to go elsewhere. He was told that he might have one chance in 100 or one in 1,000, or maybe none at all to have something accomplished by further surgery, but he had no chance without it. He replied that he had never failed to take a chance when he had one and requested surgery. As the anesthetic was about to be administered, he requested one of us (SMD) to remove all the growth seen even if he died on the table.

Considerable recurrent cancer was found in the distal portion of the esophagus and upper part of the jejunum with a large mass of involved tissue in the upper part of the abdomen. It was firmly adherent in all directions. Extension of the abdominal incision into the thorax through the eighth intercostal space gave excellent exposure after extensive adhesions were divided. The entire tumor mass was resected with wide excision including the lower third of the esophagus, upper 5 feet of the jejunum, tail and half of the body of the pancreas, 1 foot of transverse colon, and small segments of the diaphragm and left lobe of the liver which were attached to the mass (fig. 2b). A Roux-Y esophagojejunostomy and end to end jejunojejunostomy and end to end colocolostomy were complete. He received 2,500 cc. of citrated blood during the operation.

The postoperative course was again stormy, but the patient was out of bed on the second postoperative day. There was slight atelectasis of the left lung, which was relieved by tracheal suction. The colon was distended proximal to the anastomosis; so a cecostomy was performed on November 21 under local anesthesia with relief of symptoms. The next day, auricular fibrillation developed, which may have been associated with pneumothorax and possible pulmonary infarct, which was suggested by roentgen examination on November 23. Intravenous procaine brought symptomatic relief, and the thoracentesis permitted withdrawal of 1,000 cc. of air and 50 cc. of fluid. Lipiodol swallow revealed a patent stoma with no leakage. Oral liquids were increased. The course thereafter was uneventful. He tolerated soft foods well as long as he took his time in eating them and did not overeat. He complained of more pain along the ulnar nerve distribution of the left arm than was associated with digestive disturbances. In fact, he had much less difficulty in adjusting his dietary habits after this operation than after the original total gastrectomy.

Gradually the patient gained 36 pounds in weight. He remarried, saw two of his children marry, witnessed the birth of three grandchildren, resumed his duties on the federal bench and took an active part in fraternal and other activities, going to conventions all over the country. He and his wife toured Europe, he ate anything he desired in large amounts, and was indisposed only once, that being when he drank fresh tomato juice in Italy. He even climbed the Leaning Tower of Pisa, which is said to be a real feat. He continued to take pancreatin and multiple vitamins three times daily.

The patient was lax in reporting for regular check-ups, but each time he was seen, he had no complaints. Roentgen examination revealed no pathologic changes (fig. 2d). He called me in September 1953 to check his back, which he injured while tossing his granddaughter into the air. There was a low back sprain, but on further examination I found a mass, 3 cm. in size, in the epigastrium on the right side. Secondary anemia was present; the red blood cell count was 3,810,000, and the hemoglobin was 8.4 Gm. I advised re-exploration, and he accepted immediately.



A. B. C.



D.

Fig. 2. Case 2.— (a) Operative specimen, Nov. 1, 1949. Adenocarcinoma of stomach grade II. (b) Operative specimen, Nov. 14, 1950. Metastatic adenocarcinoma in lower portion of the esophagus, upper 5 feet of the jejunum, transverse colon, liver margin, diaphragm and body and tail of the pancreas. (c) Operative specimen, Sept. 17, 1953. Metastatic adenocarcinoma in duodenal stump in close proximity to the head of the pancreas. (d) Postoperative roentgenogram showing patency of esophagojejunostomy.

At operation on September 17 dense adhesions were encountered and also a tumor mass 7 cm. in diameter in the duodenal stump, attached to, but not invading, the head of the pancreas. No other metastases were found. The head of the pancreas and first and second portions of the duodenum were resected (fig. 2c), and the "small" common bile duct was anastomosed to the third portion of the duodenum with a long T tube through the narrow lumen. The gallbladder was not removed, with the thought that it might be used at a later date should common duct obstruction occur. The small portion of pancreas (3 cm.) remaining was simply closed over with interrupted cotton sutures after the ducts were ligated.

Postoperatively, there was a considerable amount of pancreatic drainage from the wound, which stopped when the Penrose drain was removed. The possibility of a pancreatic cyst developing gave concern, but it was finally decided that this might be better than a fistula. Fortunately neither developed. Except for persistent hiccups, the course thereafter was uneventful. It is noteworthy that when the hiccups were present, the long T tube was pointing cephalad in the jejunum, and when they finally stopped, the tube was again pointing inferiorly. The T tube was left in for three months and was finally removed at the insistence of the patient. I wanted to leave it in for a longer time because of the possibility of fibrous tissue or recurrent tumor obstructing the anastomosis. Since its removal, he has had occasional digestive disturbances, but he eats heartily, and his diet does not remain restricted for long. There has been no jaundice.

Recently another complication has arisen. Pain in the left flank developed. Roentgenograms gave evidence of extensive destruction of the tenth and eleventh ribs on the left side. Surgery was not advised because it was thought that this represented distant metastases and roentgen therapy might have more to offer. The patient was given 2,500 r to this site with slight improvement. There has been new bone growth in the destroyed ribs, but he continues to have pain. The course to be taken hereafter is questionable. The patient continues to act as a federal judge and carry out his usual difficult duties. Four and a half years have now elapsed since the initial total gastrectomy.*

Case 3. — Mrs. M. W., a 65 year old white woman, was admitted to St. Vincent's Hospital on Jan. 12, 1953 for a diagnostic study by Dr. Lawrence E. Geeslin. She complained of being "run down," easily tired, weak and nervous for four or five months. She had lost 13 pounds in weight in that time, but reported no melena except when taking iron, and no nausea, vomiting or diarrhea. For years there had been constipation of considerable severity and moderate flatulence at times. Her appetite was good. She complained of vague epigastric pain of several months' duration, not related to meals.

Adenocarcinoma of the fundus uteri was treated by radium and complete hysterectomy and bilateral salpingo-oophorectomy were performed in Brooklyn, N. Y., in 1945. She was examined by the surgeon and referred to an internist in November 1952 because of her present illness. A severe anemia and moderate loss in weight were noted, and she was given vitamin B_{12} injections. Roentgen examination gave negative results. It was concluded the patient had metastatic cancer probably to the liver or gastrointestinal tract, and she was given supportive therapy, but surgery was not advised. Appendectomy had been performed in 1928, and there was a history of two miscarriages and one full term pregnancy.

One aunt had cancer of the breast. The father died of heart trouble. Otherwise, the family history was noncontributory.

The patient was a well developed, fairly well nourished white woman of stated age, with evidence of moderate loss in weight. General examination showed no appreciable pathologic change except that the abdomen was flaccid without tenderness or rigidity and contained in the right lower quadrant a large firm mass approximately 6 cm. in diameter and somewhat fixed posteriorly. Carcinoma of the cecum, probably primary, was the tentative diagnosis. Urinalysis showed a faint trace of albumin and occasional white blood cells and red blood cells in the voided specimen. The red blood cell count was 3,150,000 with hemoglobin 8.1 Gm. (52 per cent), and the white blood cell count was 19,550 with 76 per cent polymorphonuclear leukocytes. Bone marrow studies gave normal results.

Roentgen examination of the gastrointestinal tract by Dr. Marvin V. McClow demonstrated a ragged conglomeration of loops of distal ileum and possibly cecum in the right iliac fossa suggesting involvement by a mass or adhesions of some kind. A barium enema revealed narrowing of the cecum with ragged irregular margins with evidence of a polypoid mass protruding into the lumen of the colon above the narrowed area. Intravenous urograms were normal.

Laparotomy was advised. The patient was given multiple transfusions until the hematocrit reading reached 41 per cent. She was given Sulfasuxidine therapy and daily enemas.

At operation on January 27, extensive pelvic adhesions were present. The transverse colon was adherent to the cecum as were multiple coils of terminal ileum. The palpable mass was inside the cecum, but there was a considerable degree of redness, induration and edema surrounding it. There were enlarged, firm nodes along the ileocolic and right colic vessels, but not along those of the middle colic vessel. The mass was adherent to the anterior abdominal wall and the dome of the bladder so that segments of these were excised well around the involved area. No other metastases were found; the pelvis showed no evidence of other tumor. The terminal 3 to 4 feet of ileum, the cecum, ascending colon, hepatic flexure and transverse colon to the middle colic vessel were resected en bloc (fig. 3, a and b). The dissection was carried to the most proximal branch of the mesenteric arteries supplying this area. End to end ileotransversostomy was performed. The patient received 1,000 cc. of blood while on the operating table and was returned to her room in good condition.

The pathologic diagnosis was a large adenocarcinoma, grade I, of the cecum with invasion of the muscularis and the serosa with a fistulous tract and neoplasm to the terminal portion of the ileum and to the transverse colon. The large lymph nodes showed considerable inflammatory reaction but no neoplasm.



Fig. 3. Case 3. — (a) Operative specimen, adenocarcinoma grade I of cecum with direct extension to ileum, anterior abdominal wall and dome of the urinary bladder. (b) The same specimen opened.

*This patient was subjected to a fourth laparotomy at his request on July 6, 1954. Metastases were too extensive for definitive surgery at this time. He died on July 26 of recurrent abdominal and hepatic metastases.

The postoperative course was uneventful with normal bowel movements after the third day. The patient was discharged in 13 days without complaints. She has led the normal life of a grandmother since that time. Recent physical examination and roentgen studies gave no evidence of pathologic change. She has no complaints.

This case is representative of a second primary tumor in one patient eight years after the first. It emphasizes the importance of giving such a patient another chance by operating to see what is wrong and doing what is indicated. Certainly the tumor was extensive, and the prognosis must be guarded in this case, but for a year and a quarter she has led an asymptomatic, useful life.

Two other cases represent similar but slightly varied points. In 1, a 60 year old white woman experienced acute intestinal obstruction one year following bilateral oophorectomy for ovarian carcinoma performed by a physician in another city, with postoperative radium therapy into the uterus and roentgen therapy. Since the pelvic tissues were fixed and edematous and the vagina adherent, he concluded that she had cancer in the terminal stage, and she was made as comfortable as opiates could make her.

The acute obstruction was relieved by intubation. The intestine was prepared, and pelvic exploration revealed no cancer, but there was matted, edematous, injected ileum fixed within the pelvis, with adjacent involvement of the sigmoid colon. This proved to be irradiation enteritis. Approximately 3 feet of the small intestine and the adherent omentum were resected, and a total hysterectomy was performed. The rectosigmoid was not removed because it was viable, the procedure was already time-consuming, and the patient was not strong. Leaving this portion of the intestine was bad judgment; there has been a considerable degree of stricture at that site with pain and frequent diarrhea. She is so much better than preoperatively that she refuses further surgery. She does her own housework and has gained 15 to 20 pounds.

In the second similar case, a 32 year old white woman was admitted as a service case on Dec. 17, 1952. She had a squamous cell carcinoma grade III, stage 2, discovered in February 1950, which was treated by irradiation and radical hysterectomy in other cities. A sigmoidovesicovaginal fistula developed, and a transverse colostomy was performed elsewhere. She complained of constant pain and was constantly wet with urine draining from the fistula. Her right kidney did not function. She was addicted to opiates. Further surgery was refused by the original doctors and others because recurrent inoperable cancer was suspected. In December 1952 laparotomy was performed at St. Vincent's Hospital. No evidence of cancer was found. Considerable irradiation reaction was encountered. The fistulous tracts and their surrounding edematous tissues were excised. The vagina, the colon and the bladder were then closed separately. The right ureter was obstructed by scar tissue near the bladder. The obstruction was excised, and the proximal ureter was reimplanted into the bladder. The postoperative course was uneventful. Unfortunately, the catheter was removed at the end of two weeks. The vesicovaginal fistula recurred immediately although it was much smaller than previously. She was able to control it much better.

Since that time she has gained 40 pounds in weight, from 85 to 125 pounds. As the colostomy was prolapsing badly, it was closed in June 1953 with good results except for frequent stools with tenesmus for a few months, followed by moderate chronic constipation. The function of the right kidney did not return; so nephrectomy was performed on the right side in April 1954 by the surgical resident, Dr. Charles H. Parent. She still has a small vesicovaginal fistula, but she shows no evidence of recurrent cancer. She still complains of pelvic pain, but it does not require opiates. She is now on the gynecologic service, and I understand plans are being made to excise the fistula again.

Case 4. — Mr. J. M., a 61 year old white man, was referred by Dr. Walker Stamps and Dr. James L. Borland in December 1951 with a diagnosis of obstruction of the lower segment of the esophagus. Roentgenograms were suggestive of a malignant lesion, but esophagoscopy by Dr. Thomas M. Irwin failed to demonstrate the tumor. Approximately nine months previously the patient had suffered an attack of severe epigastric pain diagnosed acute gastritis. This was followed by persistent substernal burning, discomfort in the left upper quadrant of the abdomen and epigastric fulness. He had experienced increasing difficulty in swallowing during the preceding four months and had been able to swallow only liquids during the three or four weeks before admission to the hospital. He had lost 10 pounds in weight during the last year, but reported no hematemesis or melena.

The patient was a well developed white man showing evidence of chronic illness and recent loss in weight. He was apprehensive but cooperative. Physical examination disclosed no evidence of pathologic change.

On examination of the blood, the hemoglobin was 14 Gm. (86 per cent), red blood cells 4,300,000, white blood cells 10,350 with 58 per cent polymorphonuclear leukocytes, and serum protein 5.7 Gm. Urinalysis gave negative results.

Abdominal exploration was performed on December 4. A large hard mass approximately 8 cm. in diameter occupied the cardiac end of the stomach. It was considered resectable; so the incision was extended into the thorax through the eighth intercostal space and the diaphragm. The neoplastic tissue extended submurally approximately 3 cm. up the esophagus. Total gastrectomy, omentectomy and splenectomy and also esophagectomy involving

the lower portion were performed (fig. 4a). The duodenal stump was closed, end to end Roux-Y esophagojejunostomy and end to side jejunojejunostomy were completed. The patient received 2,000 cc. of citrated blood while on the operating table. He was returned to his room in good condition.



Fig. 4. Case 4.— (a) Operative specimen (after fixation). Adenocarcinoma grade II of stomach with direct submucosal extension to the esophagus. (b) The patient, six months after total gastrectomy.

Histologic examination revealed adenocarcinoma, grade II, of the stomach with direct extension into the submucosa and muscularis of the esophagus, but without serosal or lymph node invasion. The upper end of the resected esophagus and the lower end of the resected duodenum showed no evidence of tumor.

The postoperative course was uneventful except for daily elevation of temperature, which was relieved after one week by oral Terramycin therapy, and thoracentesis on the left side with withdrawal of 750 cc. of serosanguinous fluid. The patient was given albumin water by mouth on the fourth postoperative day and soft foods on the sixth day without ill effects. Roentgenograms on December 11 demonstrated that the anastomosis was patent. He was discharged on the fifteenth postoperative day.

The patient had two to four stools daily, his appetite was poor, and he continued to lose weight. Gradual improvement soon followed, with appetite and strength much improved by February 1952. He attempted to return to work as a wholesale cookie salesman on March first, but he became too weak to continue. At this time, homologous serum jaundice was present, but gradually improved with rest and diet. Pancreatin, 10 grains three times daily, improved the digestion. He took oral vitamins and intramuscular liver extract. He was able to return to limited work in April. In August he attempted to carry on his full work, which included much heavy lifting (fig. 4b). Unable to do so, he became nervous and suffered from anorexia, nausea and occasional vomiting, constipation and discomfort in the left upper portion of the abdomen. He again lost weight, after having gained approximately 7 pounds. Roentgen re-examination, made by Dr. Floyd K. Hurt, demonstrated suggestive displacement of the loops of intestine in the left upper portion of the abdomen, thought to be due to a mass. Re-exploration was performed on September 3, with negative findings except for diffuse postoperative adhesions, which were causing no obstruction.

Since that time the patient has worked regularly at his usual occupation with little difficulty. He becomes increasingly irritable as he ages. His appetite is good, he eats anything he desires in moderate amounts, and he has one or two formed stools daily. He has gained 17 pounds.

Roentgenograms made March 27, 1954 gave no evidence of filling defects or obstruction. The barium meal reached the lower part of the jejunum in one hour, and no abnormalities were noted. The red blood cell count was 5,150,000 with hemoglobin 15.6 Gm on that date.

Only two and one-half years have passed since the first operation, but in view of the negative findings at operation in September 1952, and negative diagnostic findings since that time, the prognosis should be reasonably good. In any event, he has had two years of comfortable productive palliation.

Case 5. — Miss J. D., a 46 year old spinster, was admitted to St. Vincent's Hospital on Nov. 20, 1953, on referral from Dr. Edward C. Watt, with the complaint of diarrhea, persistent for three months. The onset was gradual; the diarrhea was intermittent and varied in degree from 1 to 8 stools daily. She noticed spotting of blood on one occasion, but no tarry stools, nausea or vomiting, pain or loss of weight or appetite. Roentgen study in Alabama before admission established the presence of obstruction in the rectosigmoid area. Proctoscopic examination revealed the tumor, which on biopsy proved to be an adenocarcinoma, grade II.

There was a history of poliomyelitis at 9 years of age with residual weakness of the right arm and leg. The last menstrual period occurred four years previously, but there had been slight spotting recently.

The father was living and well at 78 years of age, but had had "stomach ulcers," as had one brother. Another brother had cirrhosis of the liver.

On examination of the blood, the hemoglobin was 12.2 Gm., red blood cells 4,360,000, white blood cells 7,900 with 54 per cent polymorphonuclear leukocytes, and total protein 7.1 Gm.

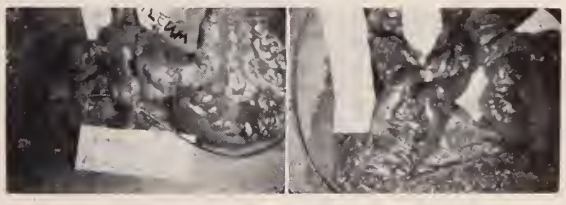


Fig. 5. Case 5.— (a) Operative specimen showing adenocarcinoma of rectosigmoid with direct extension to a segment of ileum and to left broad ligament. A second primary malignant lesion can be seen in the endocervical polyp which was adenocarcinoma grade I. (b) The same specimen with the bowel opened, but without the uterus.

At operation on November 23, a large hard mass, 5 by 4 by 5 cm. in size, was encountered in the rectosigmoid. The wall of the sigmoid was invaded by the tumor, and it was adherent to the terminal portion of the ileum and the left uterosacral ligament. The large lymph nodes present in the mesentery were not typical of metastatic nodes. A Miles abdominoperineal resection with total hysterectomy, bilateral salpingo-oophorectomy and resection of an 8 inch ileal segment was performed (fig. 5, a and b). End to end anastomosis of the ileum was completed. Because of the advanced nature of the tumor and the suspicious appearance of the lymph nodes, the dissection was carried to the junction of the inferior mesenteric artery with the aorta, and the entire left colon was removed. Considerable pelvic bleeding was encountered, and 2,500 cc. of citrated blood was given during the procedure. The patient was returned to her room in fair condition.

Histologic examination confirmed the extension of the adenocarcinoma through the serosa. There was complete obstruction of the lumen of the rectosigmoid by the tumor. The ileum had become attached to it, and a fistula had formed between the two. This accounted for the history of three months' persistent diarrhea. A small polyp presented from the cervical os. Microscopic examination of it revealed adenocarcinoma, grade I, representing a second primary malignant tumor in this patient, a not uncommon finding in patients with cancer.

After an uneventful postoperative course, the patient was discharged on the fourteenth day following the operation. She is now re-employed as librarian for a large Southern university. Although involvement of the lymph nodes was not proved and a wide resection was carried out, she should be watched closely. She is a good candidate for a "second look."

Discussion

As the cases reported indicate, extensive surgery is limited in this discussion to that surgery involving more than one abdominal organ and neighboring tissues, or involving more than a usually considered anatomic vascular segment of the gastrointestinal tract. Although this presentation is limited to those fields, I am a proponent of "adequate" anatomic surgery wherever surgery is indicated in malignant disease. Repeated surgery is defined as more than one operative procedure in the treatment of cancer. It would include the "second, third and multiple looks" advocated by Wangensteen[10,11] in the routine follow-up care of cancer patients. I have not routinely followed that practice, but as I study the problem, I am of the opinion that until something better is offered, "multiple looks" may have definite merit. Recently, I have advised follow-up laparotomies for this purpose in a few cases of gastric and colonic carcinoma with metastases to the lymph nodes. This is advised in the hope of discovering recurrence or metastases while they are still localized and minimal in extent so that removal is not difficult. The exact time for such follow-up operations is still debatable, but an arbitrary period of four to nine months has been selected.[12] Not all patients have the money or the psychologic outlook to undergo such procedures; so we surgeons should perform as extensive procedures as indicated on the "first look"[13] and hope that our results or some therapy of the future will gradually eliminate the need for further "looks."

In this study of 100 laparotomies and thoracotomies in adults for major disease of the gastrointestinal tract excluding appendectomies, cholecystectomies and benign pelvic surgery, 56 were for malignant disease in a total of 50 patients. It is noteworthy that 32 of these operations were extensive surgical procedures, 29 of which were for cancer.

It is not within the scope of this paper to go into end results since the period of time in most of the cases in the present series is too short for the usual five year evaluation, but results in the early cases of the series left something to be desired. In consequence, the scope of surgical excision was gradually extended. Of 31 operations performed for cancer from 1947 to 1951, 14 were wholly palliative because the lesion was thought to be inoperable, and 11 were extensive resections. Of 25 operations performed from 1952 to 1954, 19 were extensive procedures, and only 3 were of a nondefinitive palliative nature, indicating earlier lesions and wider resections. In these 56 cases there were 4 deaths within 10 days after the operation, and 1 occurred within 31 days. Only 2 of the deaths occurred in the last two and one-fourth years, the period during which most of the extensive surgery was performed. In 1 case terminating fatally 31 days after pancreatoduodenectomy, death was caused by hemorrhagic pancreatitis with repeated hemorrhages. The second case was one of esophagocardiectomy involving the lower two thirds of the esophagus, in which death ensued six hours postoperatively, apparently of atelectasis of the left lung caused by a large mucous plug. This patient was operated on at another hospital, and an inexperienced anesthetist gave the anesthetic after we were unable to get a more competent anesthesiologist. I learned after the operation had begun that it was the first time she had administered the anesthetic for a thoracic operation, and besides performing the surgery I had to give her numerous pointers on anesthesia. We worked with the patient constantly after completion of the operation, but to no avail. The other deaths occurring before 1952 were the result of colonic resections, all extensive; 2 were abdominoperineal and 1 a total colectomy. The latter could be attributed to inadequate preparation of the bowel, and 1 of the others to two team surgery, for which I no longer have enthusiasm. I decided it was better to avoid "the rush." The other was due to advanced carcinoma with perforation and abscess formation. Even though the procedure was performed in two stages with 16 days separating them, the patient's general condition remained poor, and infection continued. I should have waited longer before attempting the second stage. Valuable lessons have been learned from these and other patients.

Conclusions

Can it be denied that the patients in the cases presented here obtained real benefits from the surgical procedures employed? There has been definite prolongation of life, and the lives have been comfortable as well as useful. If these are extraordinary cases, they are not unlike several others in the series, though admittedly it is a small series.

Not many years ago, few, if any, surgeons would have attempted secondary operation on these recurrent cancers. Certainly I would not have attempted it. Although the cases are few, they indicate the soundness of the principle of re-exploration in any case in which the patient experiences disabling symptoms, or there is even a confirmed diagnosis of recurrent cancer in which it cannot be proved that the cancer is no longer localized.

There will be many of course who cannot be helped. But so long as we physicians do not deal in mass production, the life of any patient is important to us. Some of those patients will be found to have no cancer, and they can be given a reasonable chance for cure by removal of the symptomatic pathology. Others will have resectable lesions and can have the chance to live longer and gamble for what the future may bring.

A few suggestions may be in order. There is nothing original about them, but they have proved of benefit to me.

Esophageal surgery should be approached vigorously with an attempt at possible "cure" rather than "tongue in cheek," half-hearted, palliative resections. Naturally there are times when all obvious tumor cannot be removed, but these become less frequent when the outlook is optimistic. Malignant lesions of the esophagus have proved as frequently operable as cancers of the lung in my limited experience. At least 5 cm. of tissue should be resected above and below the confines of the tumor, and obtaining a specimen of each end for biopsy is good practice if the least doubt exists as to the extent of the lesion.

Adequate gastrectomy, be it the radical subtotal of Ochsner and Blalock[14] or total, with resection of adjoining organs and nodes which may be frequently involved, should be considered more often than it has in the past. Individual circumstances must govern each case, not general routines. In 4 out of 6 of the cases in the present series the transverse colon or its mesentery was involved, and had it not been removed, obvious cancer would have been left. Preoperative preparations for gastric cancer surgery should always include preparation of the colon in case it should be necessary to remove it. The duodenal stump and the esophagus have been found to be involved in a significant number of cases by direct extension; therefore, wide resection is imperative.

In surgery of the colon there always should be a wide anatomic dissection of the vessels at the main trunks, not simple wedge resection of the mesentery beneath the involved portion of the intestine.

Rectosigmoid and anal cancers and those of the left colon should suggest ligation of the inferior mesenteric artery at its origin from the aorta, particularly if involvement of lymph nodes is suspected. McElwain, Bacon and Trimpi[13] reported involved nodes in 60 per cent of 190 cases, and 17.8 per cent of these were located at the origin of the inferior mesenteric artery. Sacrifice of adjacent structures should rarely if ever deter one from performing an adequate resection.

Summary

Optimism is urged for all surgeons performing definitive cancer surgery. Let each patient be an individual problem, not a statistic.

More frequent use of extensive surgical procedures for the treatment of cancer of the gastrointestinal tract and related organs is advised.

Reoperation in cases of cancer in which there are disabling symptoms or confirmed localized cancer is urged if distant spread of the disease cannot be proved. "Multiple looks" at asymptomatic intervals in patients with gastric and colonic malignant lesions with nodal metastases are discussed.

A study is reported in which analysis was made of 100 laparotomies and thoracotomies performed in adults for major disease of the gastrointestinal tract. Of these, 56 were for cancer, and 5 of the cases are described in detail to illustrate favorable results in cases which would have been considered hopeless a few years ago. Vigorous surgical attack on cancer of the gastrointestinal tract is the best weapon available at this time. The belief is expressed that the future will bring better weapons and surer cures.

Cancer is being diagnosed earlier today than a few years ago, although still not early enough. This progress is evidenced by the decreasing number of inoperable growths encountered in the past two years.

References

1. Brunschwig, A.: Radical Surgery in Advanced Abdominal Cancer, Chicago, University of Chicago Press, 1947.
2. Brunschwig, A.: Extended Surgery in Advanced Cancer, editorial, Ann. Surg. 133:574-576 (April) 1951.
3. Pack, G. T.; McNeer, G., and Booher, R. J.: Principles Governing Total Gastrectomy; Report of 41 Cases, Arch. Surg. 55:457-485 (Oct.) 1947.
4. Pack, G. T., and McNeer, G.: Surgical Treatment of Cancers of Gastric Cardia, Surgery 23:976-1019 (June) 1948.
5. Pack, G. T.: Changing Prognosis for Cancer of Stomach, CA — A Bulletin of Cancer Progress 1:112-117 (May) 1951.
6. Lahey, F. H.: Complete Removal of Stomach for Malignancy, with a Report of 5 Surgically Successful Cases, Surg., Gynec & Obst. 67:212-223 (Aug.) 1938.
7. Lahey, F. H., and Marshall, S. F.: Should Total Gastrectomy Be Employed in Early Carcinoma of Stomach? Experience with 139 Total Gastrectomies, Ann. Surg. 132:540-565 (Sept.) 1950.
8. Sweet, R. H.: Results of Radical Surgical Extirpation in Treatment of a Carcinoma of Esophagus and Cardia, with 5 Year Survival Statistics, Surg., Gynec. & Obst. 94:46-52 (Jan.) 1952.
9. Pack, G. T., and McNeer, G.: End Results in Treatment of Cancer of Stomach; Analysis of 795 Cases, Surgery 24: 769-778 (Nov.) 1948.
10. Wangensteen, O. H.: Cancer of Colon and Rectum, Wisconsin M. J. 48:591-597 (July) 1949.
11. Wangensteen, O. H.; Lewis, F. J., and Tongen, L. A.: "Second Look" in Cancer Surgery; Patient With Colic Cancer and Involved Lymph Nodes Negative on "Sixth Look," Journal-Lancet 71:303-318 (Aug.) 1951.
12. Wangensteen, O. H.: Personal communication, Feb. 15, 1954.
13. McElwain, J. W.; Bacon, H. E., and Trimpi, H. D.: Lymph Node Metastases: Experience with Aortic Ligation of Inferior Mesentery Artery in Cancer of Rectum, Surgery 35:513-531 (April) 1954.
14. Ochsner, A., and Blalock, J.: Carcinoma of the Stomach; Necessity for Reevaluation of Therapeutic Philosophy, J. A. M. A. 151:1377-1384 (April 18) 1953; also in Selected Writings from the Ochsner Clinic 12:43-58 (June 30) 1953.

Medical Arts Building.

Discussion

DR. FREDERICK J. WAAS, Jacksonville: Dr. Day has given us a most excellent presentation on what might be termed massive surgery. As he mentioned, it has been my privilege to be with him in a number of these cases. In some of the specific instances I was a little hesitant possibly, but in going along further in this type of surgery, he has convinced me, and I have been definitely convinced, that we are now facing what might be termed a new look in surgery. I think it is the progressive type of surgery, of which we are going to hear a great deal. In this era of wide resections in cancer surgery, the advent of antibiotics, effective anesthesia and the blood bank has given surgeons more confidence in performing extensive and definitive operations on patients suffering from cancer. That effect has been definitely exemplified in one of the cases cited, in which the patient went into shock as nearly all such patients do, but we are so well prepared now to compete with shock that it really is not a factor anymore. Shock was feared as a contraindication to surgical intervention, and local peritonitis was also considered a reason for avoiding extensive procedures in some instances. The surgeon did as little as possible and hoped for the best.

Development in surgical technic, in anesthesia and in the physician's ability to control hypotension and infection has resulted in reversal of the age-old policy of conservative treatment in the surgery of malignant disease. Dr. Day mentioned that we must obtain definitely an optimistic philosophy, and I think it has been clearly exemplified in this presentation this morning. In instances of carcinoma of the uterus, a simple hysterectomy with removal of the adnexa is not sufficient. You should remove all pelvic glands and all ascending glands, a procedure now performed for this type of pathologic condition, which is of course pelvic exenteration. If a complete operation is performed at the first sitting, however, then the important consideration in my opinion is that pelvic exenteration will not have to be carried out. Now when a tumor is likely to recur, complete wide resection later, a wider operation, is elected at an earlier stage despite knowledge that the patient may have to accept considerable deformity and disability. I think Dr. Day has touched on that.

Total gastrectomy, normally reserved for more advanced disease, is selected earlier in carcinoma of the stomach. The principle of the en bloc operation is extended to cover not only the primary tumor but also the regional lymph nodes in carcinoma of the rectum and colon. When pathologic evidence indicates that the operation can be considered complete only by wider resection as involved carcinoma surgery, more lymph nodes are to be removed. Whenever there is every reason to hope that there is only wide local infiltration without distant spread, the extent of surgical excision is pushed to the limit. The attack on recurrent disease should be planned. To quote Dr. George Crile Jr., it is the disease and not the operation that causes death, and the first responsibility of the surgeon is to eradicate the disease.

In conclusion, I would re-emphasize that if the complete procedure is carried out at the first sitting, it may not be necessary to take a second or third look, as emphasized by Dr. Wangensteen. Do not perform an incomplete procedure and leave behind diseased tissue. Those of you who had the pleasure of hearing the presentation yesterday by Dr. Pack I am sure could not help but be impressed with the extent to which surgery has gone in the last few years. That the surgeon now can perform a total right hepatic lobectomy is, I think, a matter of great importance. I believe we are going to have to classify that as a new look in surgery.

Dr. Day, concluding: I appreciate Dr. Waas' remarks. Again I should like to urge that we be ever on the watch for cancer, that we discover it early and that we treat it early and vigorously.

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Vagotomy and Gastroenterostomy for Duodenal Ulcer

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CHICAGO

For many years a subtotal gastric resection for duodenal ulcer has been the operation of choice by the majority of surgeons. The proper technical details of this operation have been worked out by the trial and error method in thousands of patients. It has now been established that an adequate resection for the control of gastric acidity requires the removal of at least two thirds of the stomach.

The percentage of satisfactory results following this operation differs rather widely in published statistics. Most of the American surgeons, with wide experience in this operation, report that their satisfactory long range results vary between 85 and 95 per cent. Reports from other countries often indicate a much lower percentage. The immediate operative mortality from subtotal gastric resection in the hands of the experienced surgeon should be less than 2 per cent. It is, undoubtedly, at least twice this figure or 4 per cent the country over, if one bears in mind that subtotal resection as performed for duodenal ulcer is under discussion.

My associates and I have had approximately 90 per cent satisfactory results from this operation. The immediate poor results or surgical fatalities are usually the result of leakage of the duodenal stump. The hazard of resection of a chronic duodenal ulcer perforating into the head of the pancreas are such that many surgeons now, in such cases, prefer to leave the ulcer in situ and to close the duodenum or pyloric canal proximal to the ulcer. Other surgeons have abandoned resection in such cases in favor of vagotomy and gastroenterostomy.

During the early postoperative period, many patients, following resection, have been troubled with the so-called 'dumping syndrome,' and this is often extremely distressing and difficult to control although the symptoms generally disappear within a matter of three to six months. Other late ill effects of subtotal resection for duodenal ulcer are several. One is the development of a gastrojejunal ulcer, the frequency of which appears to be in the neighborhood of 5 per cent. It is most prone to occur in those patients with a high preoperative acidity. Some surgeons now advocate the use of vagotomy together with subtotal resection in selected cases with high acidity. Frequent complaints after gastric resection are the inability to eat a general diet and the failure to gain weight. These effects are explained by the serious disturbance of the normal digestive processes due to the rapid passage of food through the jejunum. This interferes with the proper action of the digestive juices of the upper part of the intestinal tract on the food.

Recent studies at the University of Illinois[1] indicate that the amount of fat lost in the stools after a two-thirds gastric resection is about twice the normal amount, but the protein loss is six times normal. The wider the resection the more likelihood of a cure of the ulcer problem but the greater the nutritional disturbance. Many patients, after a resection, find that they are unable to follow a general diet, and a definite percentage of them manifest a secondary anemia.

Owren[2] of Norway estimated an anemia to be present in 25 to 50 per cent of his patients after gastrectomy and blamed this result on the lack of proper absorption of iron and vitamin B_{12} from the upper part of the intestinal tract. This and other objections to the conventional two-thirds resection for duodenal ulcer have stimulated surgeons and physiologists to restudies of this problem, and some[3] are now advocating a return to the old Billroth 1 procedure in which the stump of the stomach after subtotal resection is anastomosed directly to the end of the duodenum.

Vagotomy

About 10 years ago, largely through the work of Dragstedt of the University of Chicago, interest was renewed in the use of vagotomy or resec-

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tion of the vagus nerves in the treatment of peptic ulcer. This was not a new idea, as physiologists had recognized for many years that the stimuli which passed through the vagus nerves were important factors in the production of gastric juice. It has now been demonstrated beyond question that sectioning of the vagus nerves results in a decided decrease of the secretion of hydrochloric acid and also causes a decrease in the tone of the gastric musculature, resulting in atony of the stomach. The other major influence in the secretion of hydrochloric acid lies in the antrum or lower fourth of the stomach. Many years ago Madlener showed that removal of the antrum of the stomach caused a decrease in gastric acidity and would permit the healing of certain peptic ulcers. On the basis of these and many other observations on experimental animals, Dragstedt postulated that peptic ulcer is due entirely to a hypersecretion of gastric juice. The theory that there must be some local defect or devitalization of the mucosa of the stomach or duodenum can be abandoned. He further concluded that duodenal ulcer is due to a hypersecretion resulting from nervous stimulation through the vagus nerves, while gastric ulcer is due to a hormonal stimulus, the hormone being "gastrin" derived from the antrum of the stomach when it comes in contact with food.

Vagotomy alone was performed on a large number of patients before it was realized that this operation must be complete and combined with gastroenterostomy to obtain satisfactory results in the majority of patients. It has further been learned by the trial and error method that certain technical details in the performance of both the vagotomy and the gastroenterostomy must be followed. The American Gastro-Enterological Association has made a comprehensive survey of the results of various gastric operations in the treatment of duodenal ulcer. Some of their conclusions seem to be based on incomplete evidence, but one statement in their report deserves comment. In the discussion of vagotomy and gastroenterostomy for duodenal ulcer, the report indicated that those surgeons who had used this operation in 50 or more patients reported definitely better results with it than did those surgeons who had used the operation in less than 50 patients. In our experience I am sure that we performed incomplete vagotomies in a considerable number of our early patients.

Anatomic studies indicate that in about 5 per cent of humans, one or both of the vagus nerves branch in the thoracic part of the esophagus and their filaments extend down in the musculature of the lower end of the esophagus in such a manner that the surgical section of all of these filaments is obviously impossible. It would seem, then, that complete vagotomy cannot be accomplished in about 5 per cent of patients. Grimson and his co-workers[4] have arrived at about the same conclusion on the basis of gastrometric studies. The identification at operation of the two major vagus nerves and accessory branches requires practice, and we found that cadaver dissection was especially valuable to us in our early experiences with this operation. The vagus nerves and associated filaments, which may number from one to four, can seldom be identified by direct vision. They must be dissected out with the fingertips and identified by the sense of feel. We now completely denude the lower end of the esophagus of the surrounding fat and peritoneal tissues, trace the two major vagus nerves and any sizable filaments up into the mediastinum and excise segments of all of these nerves, segments which will vary from 2 1/2 to 10 cm. in length (1 to 4 inches). The upper ends of the nerves are cut off under traction, and the proximal ends retract upward out of sight in the mediastinum. The lower ends are dissected down the walls of the stomach and are ligated after cutting because of the frequency with which they are associated with small blood vessels at this level. In the complete uncovering of the esophagus sizable arteries and veins may be encountered and require ligation. The adjacent spleen can be traumatized by carelessness, and occasionally direct venus communications between the paraesophageal vessels and the hilus of the spleen can produce troublesome bleeding. On two occasions we have had to perform splenectomy to control this bleeding, but no real difficulties with bleeding have been encountered in our last 150 cases.

Gastrojejunostomy

The performance of the gastrojejunostomy involves attention to certain details. Its function is to permit adequate emptying of the stomach, particularly if there is already some obstruction of the duodenum by the ulcer. It also must be borne in mind that with the healing of the duodenal ulcer further scar tissue contraction may occur and produce partial or even

complete pyloric obstruction. The new stoma must, therefore, be adequate in size and should admit easily two fingertips. If obstruction is already present or seems likely, the stoma should be made large enough to admit the tips of three fingers. If the stoma is too small, later contraction of it may close it completely. If it is too large, a dumping syndrome may result. It is obvious that if it is going to drain properly, it must be located in the dependent part of the stomach. A high-lying gastrojejunostomy not only does not allow proper emptying of the stomach, but it actually stimulates gastric secretion.[5] It should be located in the antral portion of the stomach with the distal end of the stoma within 2 inches of the pylorus. Crile[6] recommended that the incision in the stomach be made parallel to the greater curvature. For several years we have been making the stomach incision somewhat diagonal extending from near the lesser curvature to the greater curvature and from the patient's right to left on the posterior wall of the stomach. We have favored the somewhat diagonal incision because it permits the distal portion of the jejunum then to extend downward and to the patient's left. This procedure permits better emptying of the stomach with less likelihood of a regurgitation of gastric contents into the proximal loop. The distal or efferent loop of the jejunum is always attached to the greater curvature end of the incision with a posterior gastroenterostomy. We use two rows of 00 chromic catgut with one external row of interrupted fine cotton sutures. The cotton sutures are probably unnecessary, but they give the surgeon a further sense of security, and inasmuch as we have never had any trouble with them, we have continued their use.

The length of the proximal loop between the ligament of Treitz and the attachment of the jejunum to the lesser curvature side of the stoma deserves comment. This should be reasonably short, preferably 3 to 5 cm. (1 to 2 inches), but the length must vary depending on several factors which can only be learned by surgical experience. Account must be taken of the size of the stomach, the distance of the greater curvature from the proximal portion of the jejunum, the location of the middle colic artery in the mesocolon and particularly the obesity of the mesocolon is such that a posterior gastrojejunostomy cannot be performed satisfactorily. These patients must then have an anterior gastrojejunostomy, and it is then necessary, as a rule, to resect a large portion of the omentum which is attached to the mid-transverse colon. If the small bowel is elevated over a large omental fat pad, it makes the proximal loop much too long. One should not pull the proximal portion of jejunum through an opening made in the omentum as there is too great a danger of constriction through this opening.

The opening in the transverse mesocolon must be sufficiently large so that the edges of the opening can be readily sutured to the posterior gastric wall around the new stoma. If this opening is too small, particularly in obese patients, edema postoperatively may narrow it and constrict the stoma in such a way that the stomach will not empty into the distal loop. Three of our patients had nonfunctioning gastroenterostomies, and 10 to 20 days following operation it was necessary to reoperate upon them. In all 3 cases we found that the stomach had contracted upward pulling the two loops of jejunum through an edematous, narrowed, constricting opening in the mesocolon.

In the postoperative care following vagotomy and gastrojejunostomy it is important to keep the stomach completely decompressed for a period of 48 to 72 hours. In some patients reinsertion of the Levin tube is necessary for an additional few days. For the first week after the removal of the tube the feedings must be small in amount and cautiously given, starting with 1 ounce an hour of clear liquids on the first day after the removal of the tube. Within five days these patients can be given five small feedings a day. Meat is added in three weeks, and within two months most of them are on a completely general diet. During the first two months they are urged to be content with small portions taken frequently. We have had a number of patients who have gotten into difficulties because their freedom from pain has been so gratifying that they have overindulged with large meals and have suffered a gastric distention.

In discussing the relative merits of vagotomy with gastroenterostomy and gastric resection, it should be borne in mind that one should consider various factors in comparing two series of cases. These factors include the emotional status of the patient, the duration and character of the symptoms, the history of complications, such as perforations, hemorrhage and obstruction, the tech-

nic of the operation performed, the experience of the surgeon in performing it, the length of the postoperative observation and perhaps more than anything else, the testimony of the patient himself. Follow-up studies of night secretions and gastric acidity, roentgen findings, response to insulin and histamine tests, et cetera, are all of scientific interest, and help in analyzing failures following any gastric operation. Regardless of what such tests may show, if the patient himself is satisfied with his operative result, the operation has been a good one.

Table 1. — Vagotomy and Gastroenterostomy for Duodenal Ulcer

253 patients followed 6 months to 6 years			
	Results		
	Number of Patients	Per Cent	
Excellent	178	70.5	91 per cent
Good	52	20.5	satisfactory
Fair	14	5.4	9 per cent
Poor	9	3.6	unsatisfactory

Analysis of Cases

We have now performed 269 vagotomies and gastroenterostomies for patients with duodenal ulcers and have followed 253 or 94 per cent of them (table 1) over a period of from six months to six years. Two hundred and thirty, or 91 per cent, reported their results to be satisfactory, either excellent or good; 23, or 9 per cent, reported unsatisfactory results which were either fair or poor. About 80 per cent of these patients are contributors to the Illinois Central Hospital Department and they can return to the hospital for further study at no additional expense to themselves, if they are not satisfied with their progress. As a result, our patients with bad results do return in the great majority of cases, and we can personally study them. Many of the others have been seen at the hospital for other conditions since their operation for ulcers. Those who have not returned have been contacted by questionnaire. The testimony of the majority of these patients is almost euphoric, and to a large extent they constitute the most satisfied group of patients that we have encountered after any operation for any disorder. Most of them are able to eat a completely general diet, are satisfied with their weight, and anemia is not a problem. Their enthusiasm for this operation is not matched by the reports of those on whom we have performed subtotal resections.

In this series of 269 cases there have been 3 postoperative deaths, all studied at autopsy. One patient died of coronary thrombosis 48 hours after operation. Enterocolitis has been a troublesome problem in a few postoperative cases in recent years, and 1 death from this cause occurred 12 days after operation. ACTH gives promise of being most valuable if used early in the cases in which a severe diarrhea develops following any abdominal operation. One patient died of alkalosis and uremia 14 days postoperatively. The major postoperative complications (table 2) included some degree of wound disruption in 4 cases, and resuture was necessary in 2 of these. In 3 there was pneumonia postoperatively. Previously mentioned were 3 cases requiring reoperation for stomal obstructions. In 2 there developed rather severe thrombophlebitis, but there were no cases of pulmonary embolism. In the first year of our experience with this operation, there was 1 case in which pneumothorax occurred due to the accidental puncture of the left pleura in performing a vagotomy. In 2 cases significant wound infection developed, but healing followed without draining sinuses. These 15 cases with major postoperative complications constitute 5.6 per cent of the total after exclusion of the 3 cases in which death ensued.

Table 2. — Vagotomy and Gastroenterostomy for Duodenal Ulcer

Major Postoperative Complications — 269 Cases		
Wound disruption	4	
Pneumonia	3	
Pneumothorax	1	
Stomal obstructions requiring reoperation	3	
Thrombophlebitis	2	
Wound infection	2	
Total	15	5.6 per cent

In a previous report made on this subject about one year ago, at which time we analyzed 168 cases (table 3), we compiled the data on the type of results in the patients followed depending on the duration of the follow-up. From these data we concluded that if the patient had a good result within the first six months after operation, he could expect to have a good result after four years. Analysis of postoperative gastric acidity gives some clue as to the result that may be expected. The patients with poor end results generally showed a higher postoperative acidity than did the ones with good results. This would

Table 3. — Results by Years of Follow-Up

Period	Number of Patients	Satisfactory Number	Satisfactory Per Cent	Unsatisfactory Number	Unsatisfactory Per Cent
6 months - 2 years	83	75	90.4	8	9.6
2 - 3 years	47	43	91.5	4	8.5
3-4 years	18	17	94.4	1	5.6
4 years and over	20	18	90.0	2	10.0
Totals	168	153	91.1	15	8.9

indicate that the poor results were to some extent, at least, due to incomplete vagotomy.

In cataloging the results the word "excellent" is used to mean that the patient is essentially normal in gastrointestinal function, has no pain, eats a general diet, requires no medication and is completely satisfied with the operation. A "good" result means a satisfied patient, free of pain and requiring no treatment, but complaining occasionally of some diarrhea, bloating, gas, or inability to eat certain foods. A "fair" result means that relief of pain had been achieved, but definite limitations in diet are necessary. In this group have been placed those patients who have some distressing diarrhea, have had black stools at least once or have required medication at times. Some of these patients consider the result of their operation as satisfactory because of the relief of pain. The "poor" results are those observed in patients who have shown no improvement or manifest other symptoms that are disabling and who are unhappy with the result. A thorough postoperative study of the patient may obtain information that is not forthcoming in a questionnaire and may show that the result is not as good as the patient thought it to be. We have found the opposite also to be true, and later studies on several patients have revealed other pathologic processes, such as cholecystitis or diverticulitis of the colon, to be the explanation of symptoms ascribed by the patient to a poor result of the operation for ulcer.

Among the cases with unsatisfactory results (table 4) there were 7 in which stomal ulcer was suspected, because of a history of pain and episodes of black stools. All of these 7 were studied by roentgen examination or gastroscopy or both, and a stomal ulcer was proved in only 1 case. There were 3 cases in which the patient complained of diarrhea lasting over six months. In about 15 per cent of the cases there is a tendency to loose stools for the first three months, but this can usually be readily controlled by diet. Our worst results were in cases in which the patient was emotionally unstable and a diagnosis of psychoneurosis was justified. We all recognize that many patients of this type will not do well with any operation. We have been impressed by the fact that the evidence of ulcer in some of these neurotic patients is highly questionable and we have ceased to recommend surgery for them unless they have clearcut evidence of a chronic duodenal ulcer which is resistant to adequate medical management. On eight occasions we have found at operation that there was little or no scarring, induration or deformity of the duodenum and that we could not definitely state that an ulcer was present. Some of these patients have done well following vagotomy and gastroenterostomy, but 3, or 37.5 per cent, have not.

Table 4. — Summary: Vagotomy and Gastroenterostomy for Duodenal Ulcer

269 operations, 253 patients, or 94 per cent, followed
230, or 91 per cent, satisfactory (excellent or good)
23, or 9 per cent, unsatisfactory (fair or poor)

	Number	Per Cent
Deaths	3	1.1
Postoperative complications	15	5.6
Disabling late diarrhea	3	1.2
Bleeding (stomal ulcer?)	7	2.7
No ulcer found at operation	8	3.0
(Poor result in 3, or 37.5 per cent)		

During recent years at the Illinois Central Hospital, from 15 to 20 per cent of the patients treated by the Medical Service for duodenal ulcer have been referred for surgical treatment (table 5). More than one indication for operation existed in many of these patients. Approximately 65 per cent had pain as a prime indication while 24 per cent stated that they had had at least one episode of bleeding. Eleven per cent showed clinical and roentgen evidence of pyloric obstruction. The duration of symptoms was more than three years in 72 per cent of our cases, and in 12 per cent there had been surgical closure of at least one perforation in the past.

Table 5. — Indications for Surgery in Duodenal Ulcer (15 to 20 Per Cent of All Patients)

	Per Cent
Pain	65
Bleeding	24
Obstruction	11
Symptoms over 3 years	72
Perforation	12

As our observation of these patients has extended over recent years, we have become more and more satisfied with vagotomy and gastro-

enterostomy in the treatment of duodenal ulcer. This operation takes less time to perform than resection, and carries a lower morbidity and mortality. In the last three years we have performed gastric resection for duodenal ulcer only in those patients who are operated on as emergencies and because of severe active bleeding. A history of past bleeding is no contraindication to vagotomy and gastroenterostomy. We believe that vagotomy and gastroenterostomy have been discredited by some authors for unsound reasons. Some have admitted that they use this operation only in cases in which they are not satisfied that an ulcer actually exists and in which they do not feel justified in removing two thirds of a patient's stomach in the absence of definite evidence of ulcer. Others have stated that they reserve vagotomy and gastroenterostomy for the patient who is a poor risk. One surgeon, who prefers gastric resection, stated that he uses vagotomy and gastroenterostomy for duodenal ulcer in highly nervous middle-aged men with large ulcers. We would like to repeat that the only fair way to assess the relative values of these two operations is to perform them on comparable series of patients.

Summary

In summary, 269 patients were subjected to vagotomy and gastroenterostomy for duodenal ulcer, and the great majority of them were followed for from six months to six years. The results were satisfactory in 91 per cent and unsatisfactory in 9 per cent. In only two instances did we recommend reoperation because of evidence of a stomal ulcer, and operation was refused in both cases. One advantage of vagotomy and gastroenterostomy is that if it proves a failure, a later resection is still a possibility. We have outlined the technical details to be observed in this operation as we have learned them from our own experience, and have discussed the major complications which we have seen.

In conclusion, I should like to repeat the statement that we made in a previous article[7] that vagotomy with gastroenterostomy will give as good end results as subtotal resection in comparable cases of duodenal ulcers. This operation has the further advantages of requiring less time to perform, carrying a lower surgical mortality, and not showing as high a percentage of late complications such as malnutrition and anemia.

References

1. Javid, H., and Cole, W. H.: Nutrition in Gastric Surgery. Paper read before the Chicago Surgical Society, April 2, 1954.
2. Owren, P. A.: Pathogenesis and Treatment of Iron Deficiency Anemia After Partial Gastrectomy, Acta. chir. scandinav. 104:206-214 (Dec. 10) 1952.
3. Moore, H. G. Jr., and Harkins, H. N.: Critical Evaluation of Billroth I Gastric Resection, Surgery 32:408-425 (Aug.) 1952.
4. Rowe, C. R. Jr., and others: Early and Late Effects of Vagotomy on Gastric Secretions and Motility, Surgery 32:226-250 (Aug.) 1952.
5. Zubiran, J. M., and others: Quantitative Studies on Effect of Gastrojejunostomy on Gastric Secretion, A. M. A. Arch. Surg. 65:239-249 (Aug.) 1952.
6. Hoerr, S. O.; Brown, C. H.; Rumsey, E. W., and Crile, G. Jr.: Duodenal Ulcer; Results of Treatment with Subdiaphragmatic Vagus Resection and Gastroenterostomy; Interim Report, J. A. M. A. 149:1437-1440 (Aug. 16) 1952.
7. Guy, C. C.; Werelius, C. Y., and Dexter, D. H.: Five Years' Experience with Vagotomy and Gastroenterostomy for Duodenal Ulcer, J. Internat. Coll. Surgeons 19:313-321 (March) 1953.

5800 Stony Island Avenue.

Treatment of Dendritic Ulcer of The Cornea With Topical Ether

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The herpetic infiltration of the cornea known as dendritic ulcer is usually regarded as a fairly serious eye condition that requires from one to several weeks to heal and often leaves a permanent opacity.

The majority of ophthalmologists and the authors of standard textbooks on ocular therapy do not seem to have been completely satisfied with any of the various treatments used for dendritic ulcer. Each new chemotherapeutic drug and antibiotic agent since sulfanilamide has been tried and discarded in favor of the next newer discovery. In 1948, an English author, Hughes,[1] reported 16 cases treated with daily applications of a sulfonamide solution and ointment. He obtained "good results" in 6 cases, "fair" in 6 others, and "poor" in the remaining 4.

Read before the Greater Miami Eye, Ear, Nose and Throat Society, Miami, May 12, 1954.

Zeller and O'Conner,[2] in 1950, treated 7 cases of dendritic keratitis with Aureomycin solution, and in all the ulcers were healed in four to 21 days. There was no mention of scarring or the final visual acuity.

Other methods of recommended therapy include application of iodine solution, instillation of quinine bisulfate ointment and treatment with roentgen rays.[3]

An experimental study on rabbit corneas infected by the herpes virus showed that neomycin, Aureomycin, orange dye, Terramycin, chloramphenicol and cortisone were of no value in arresting the disease process.[4]

In 1941, Kronenberg[5] reported a new and simple method of treating dendritic keratitis and claimed remarkable results. He used anesthetic ether applied to the lesion with a small cotton-tipped applicator. In his first 8 cases the lesion healed after one to 10 applications. Again in 1950 he reported 12 additional cases of his own and 8 cases treated by a resident ophthalmologist under his direction.[6] All these ulcers healed in one to six days (average 2.2 days) with only one to three applications (average 1.5). This method of using ether for the treatment of dendritic ulcers certainly appeared to excel any other known therapy, but apparently ophthalmologists have been slow to adopt it as the treatment of choice for this condition.

During the past eight years I have used the anesthetic ether cautery for treatment of dendritic ulcer of the cornea in all the cases that have come under my care, and I have modified Kronenberg's original method to a certain extent. I have never found it necessary to apply ether more than one time to initiate complete healing in every case.

Method

After the diagnosis of dendritic ulcer of the cornea has been made by fluorescein staining and slit lamp examination, the cornea is anesthetized with 0.5 per cent solution of Pontocaine applied topically. A tightly wound cotton-tipped toothpick is dipped into ether and immediately applied to the affected area of the cornea. The epithelium of the entire distribution of the lesion plus a generous margin is rubbed free from Bowman's membrane and removed. The applicator may have to be moistened two or three times to complete the procedure. One should not hesitate to remove the epithelium all the way to the limbus if necessary. One can judge the amount of epithelium that must be removed by continuing the removal as long as the tissue separates readily. The procedure may be stopped when the point is reached at which the epithelium rubs off with considerable reluctance. A final firm scrubbing is given to the denuded area. It should be emphasized at this point that the ophthalmologist should not err on the side of conservatism, but should be certain to remove an adequate amount of epithelium.

A drop of a 4 per cent solution of homatropine and an antibiotic ointment of the ophthalmologist's choice are instilled into the conjunctival sac and an eye pad applied. I permit the patient to use Pontocaine ophthalmic ointment as needed until the epithelial surface has regenerated, and I have not found that it significantly retards healing. The eye is dressed daily until the epithelial defect heals and does not stain with fluorescein.

Results

The most recent 12 cases are here reviewed. The characteristics of the corneal lesions are shown in figure 1. All healed in one to three days following only one ether cautery treatment. Three patients had faint scarring of the cornea immediately after healing was completed, but the corneas became clear after a few weeks. These 3 patients had had ulceration for three to seven days before seeking treatment. Two other patients had some permanent scarring of the cornea, but both had had previous attacks of dendritic ulcer and probably had the opacities before the present attack. During this period 1 patient seen by me in consultation was being treated with Aureomycin ophthalmic ointment. His ulcer required 14 days to heal, but left no scar. This 1 case illustrates the great shortening of the disability period when ether cautery is used in preference to antibiotic therapy.

One patient had a recurrence of dendritic keratitis four months after treatment with ether. This patient had also had one previous attack. She was treated elsewhere for the third ulcer. Various antibiotics and cortisone were used. Iodine cautery was employed several times, but the lesion failed to respond and progressed into a severe iritis with subsequent blindness.

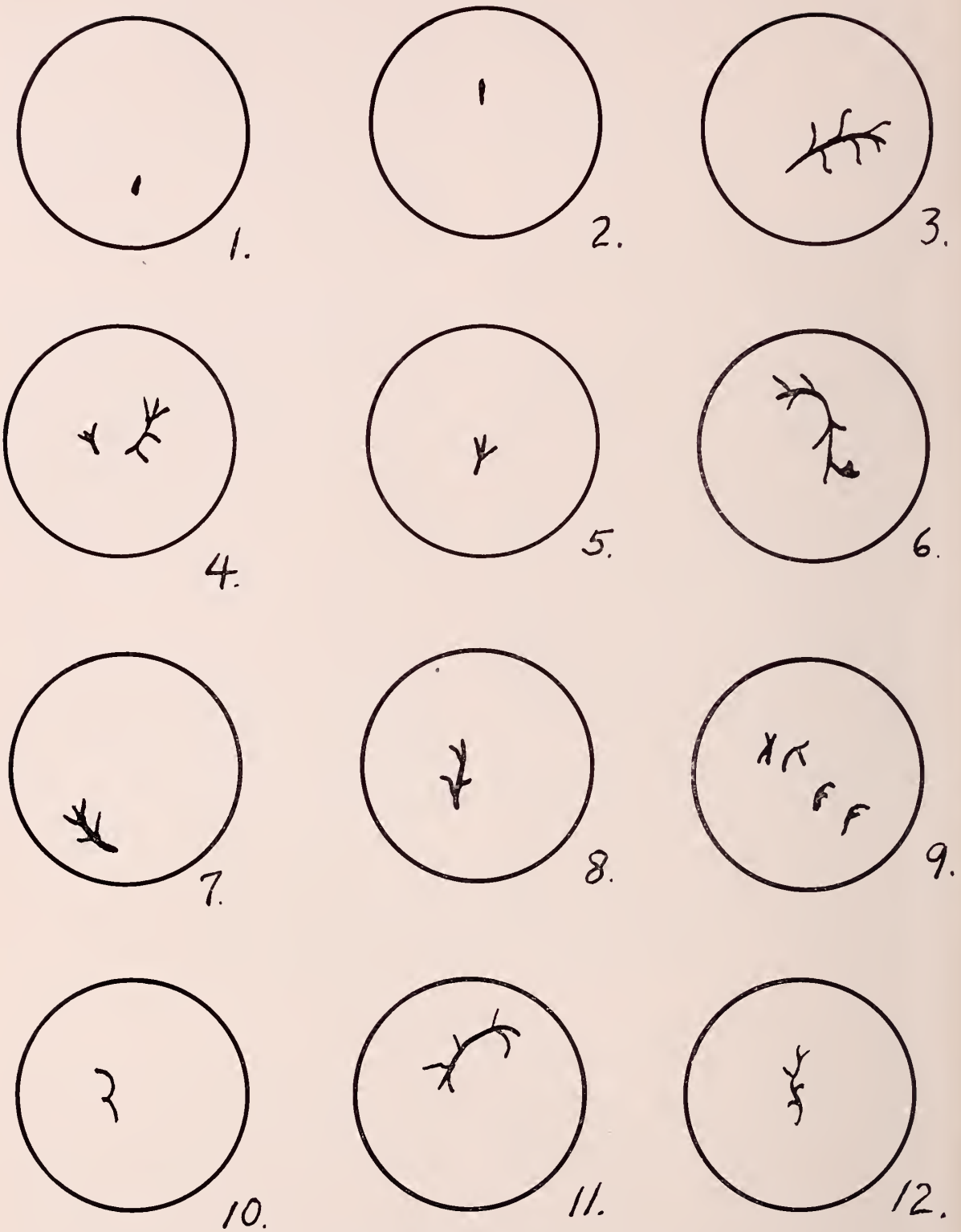


Fig. 1.— Dendritic Ulcers of the Cornea. Cases 1-12.

Discussion

The mechanism of action of ether in curing dendritic ulcer of the cornea is not well understood. I believe it works in two ways. First, the herpes virus is mechanically removed from the cornea along with the epithelium in which it resides. Secondly, the ether probably dissolves the lipids of the corneal surface and destroys the virus it thus readily reaches.

The advantages of the ether cautery method are:

1. It brings about more rapid healing than any other type of treatment.
2. It is simple to perform.
3. The patient experiences no pain.
4. The patient need not be hospitalized, confined to bed or, in most cases, even prevented from continuing his present occupation during the treatment and healing period.
5. No scarring of the cornea is attributable to the cautery such as sometimes occurs with iodine.

The only disadvantage I have ever encountered is the difficulty of carrying out a thorough corneal scrubbing on children with dendritic ulcer.

Summary

The treatment of dendritic ulcer of the cornea with topically applied ether is described. Results in 12 cases are presented. All lesions healed in one to three days after only one treatment. The advantages and the one disadvantage are discussed. It is concluded that the ether treatment of dendritic ulcer of the cornea far surpasses any other type of therapy and promises great satisfaction to any ophthalmologist who uses this procedure as herein described.

References

1. Hughes, H. L.: Local Sulphonamide Therapy of Dendritic Ulcer, Brit. J. Ophth. 32:43-46 (Jan.) 1948.
2. Zeller, R. W., and O'Conner, E. F.: Treatment of Dendritic Keratitis with Aureomycin, Am. J. Ophth. 33:619 (April) 1950.
3. Selinger, E.: Office Treatment of the Eye, Chicago, The Year Book Publishers, Inc., 1947, p. 320.
4. Hallett, J. W., and others: Treatment of Experimental Herpes Simplex Keratitis in Rabbit, A. M. A. Arch. Ophth. 46:33-38 (July) 1951.
5. Kronenberg, B.: Treatment of Herpetic Keratitis with Ether, Arch. Ophth. 26:247-249 (Aug.) 1941.
6. Kronenberg, B.: Further Report on Use of Ether in Treatment of Herpetic Keratitis, New York J. Med. 50:2825-2826 (Dec. 1) 1950.

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I. Electrocardiographic Changes in the Intermediate Coronary Syndrome

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and
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The correct diagnosis of coronary artery disease and the proper evaluation of patients with this disease constitute an old but nevertheless ever new problem. Acute pain, due to myocardial ischemia, is one of the most important symptoms that the clinician encounters. On one hand, there is the patient with acute coronary pain who has simple angina. The characteristic clinical picture is all too common. There is the transient pain in the chest brought on by exertion and anxiety, which is of brief duration and is usually relieved by nitroglycerin. If electrocardiograms are taken during the pain, temporary RS-T and T wave changes may be seen. On the other hand, there is the picture of acute myocardial infarction. The variations in the clinical picture, the variations in the electrocardiographic pattern, and the usual picture of fever and leukocytosis are all too well known.

In between these two extremes of angina and myocardial infarction, there is a clinical picture which is something more than angina and something less than myocardial infarction. Its proper place in the over-all picture of coronary artery disease has been a subject of much discussion. It has been called various names, among them acute coronary insufficiency,[1,2] coronary failure,[3] and atypical myocardial infarction. We prefer to use the term first suggested by Graybiel,[4,5] namely, the intermediate coronary syndrome, for reasons which have been adequately discussed by him.

Read before the Florida Heart Association, Scientific Session, Tampa, Sept. 14, 1953.

It is difficult to estimate the incidence of these attacks which, though more severe than angina pectoris, yet fall short of infarction. Some clinicians, like ourselves, think they see a great many cases of this intermediate coronary syndrome; others say that it is rarely seen. Littman and Barr,[6] who called this particular syndrome acute coronary artery insufficiency, noted that of all their patients with acute coronary artery disease, almost 30 per cent had atypical and less extensive myocardial injury than those with acute definite infarcts. Master and Jaffe[7] reported that of a group of 570 patients with acute coronary episodes, in 200, or 36 per cent, the disease was diagnosed as acute coronary insufficiency, and in the remaining 370 as acute myocardial infarction.

The following 2 cases are presented as typical examples of intermediate coronary syndrome.

Report of Cases

Case 1.—J. J., a 58 year old white man, on Feb. 16, 1951, complained of substernal pain radiating to both shoulders. The pain was severe, was accompanied by shortness of breath, and lasted approximately three to four hours. When examined, he was having no pain. An electrocardiogram showed evidence of recent myocardial damage, and he was hospitalized. The course in the hospital was completely uneventful; the pain did not recur, and he was comfortable. At no time was there fever or leukocytosis. The blood pressure and pulse rate always remained within normal limits. An electrocardiogram taken on February 16 showed diphasic to symmetrically inverted T waves in lead I and isoelectric T waves in V5 and V6 (fig. 1). An electrocardiogram on February 19 showed some improvement. The T wave in lead I became upright; the T wave in V5 was more nearly upright; the T wave in V6 was still isoelectric. By February 21, there was an essentially normal electrocardiogram. The T wave which was originally inverted in lead I was now upright; the T waves over the left side of the precordium were now upright. He was discharged on February 21, five days after admission, completely asymptomatic.

It will be noted that although the pain was severe and lasted three to four hours in this case, there was complete electrocardiographic and clinical reversal in five days. The next case presented is one in which there was complete clinical and electrocardiographic reversal by the end of six weeks.

Case 2.—H. C., aged 54, had experienced pain in the chest on exertion, which was relieved by nitroglycerin, for approximately one year. The pain was substernal, sharp, and characteristically anginal. Physical examination on Feb. 21, 1953, revealed no significant abnormalities. The blood pressure was within normal limits. An electrocardiogram on March 26 gave no evidence of significant abnormalities (fig. 2). In the early morning of April 20 he again complained of severe substernal pain, which was similar in nature to that previously experienced, but was much more severe and shocking. The blood pressure and pulse were good. He was given sedation and hospitalized. By the next morning, the pain had gone. The course for three weeks in the hospital and three weeks at home was completely uneventful (fig. 2).

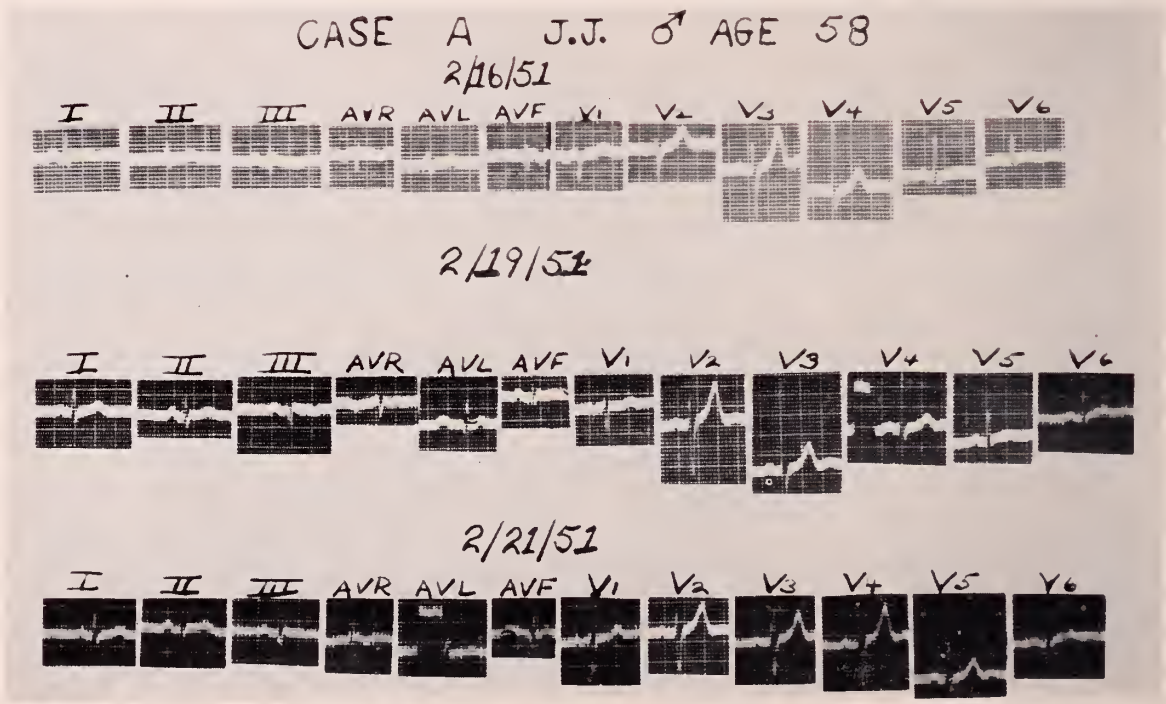


Figure 1.

An electrocardiogram, taken the day after the pain was experienced on April 20, showed pronounced T wave changes, with inversion and flattening of the T waves in all the standard leads; there was slight depression of the ST segments over the right side of the heart in leads V2 to V4, with diphasic T waves to be seen in V5, V6, and AVF. Further progression with deeper inversion of the T waves in the standard leads and in the precordial leads was demonstrated in subsequent tracings on April 24. By May 4 some of the changes were diminished. The slight ST depression in V2, V3, and V4 was gone. The T waves in the standard leads were less inverted than they had been. This change was also true of the T waves in V5, V6, and AVF. By May 16, less than four weeks after the onset of the episode, there was further regression, but there was still inversion of the T waves in leads I and II, although the T wave in lead III was becoming upright. Two weeks later, on May 30, there was complete reversal to normal, with the T waves upright in all the standard leads and in all the precordial leads.

was classic electrocardiographic evidence of myocardial infarction, which usually included characteristic QRS changes. When QRS changes were not present, however, the T wave changes were always extensive and prolonged, and in all cases the evidences of myocardial damage were still extensive and definite after six weeks. In many cases, fever and leukocytosis were present. In the cases classified as intermediate coronary syndrome were included those in which there was definite thoracic pain of the type associated with coronary artery disease; it was usually more severe than that of angina and less severe than that

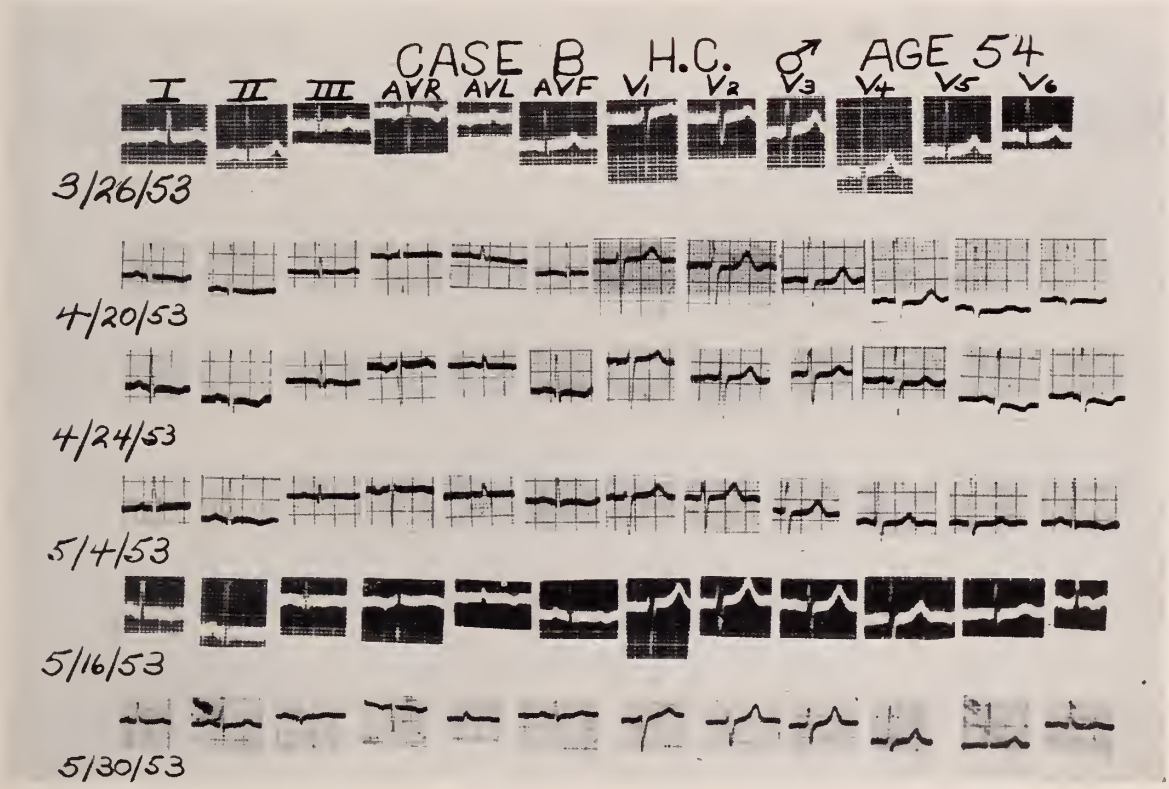


Figure 2.

Analysis of Cases

In our series of 76 cases in which the patients were hospitalized for acute coronary pain with resultant electrocardiographic abnormalities, 19, or 25 per cent, were classified by us as cases of intermediate coronary syndrome; the remainder were cases of acute myocardial infarction. This is the same order of magnitude as the 30 per cent reported by Littmann and Barr[6] and the 36 per cent reported by Master and Jaffe.[7] In the cases classified as coronary occlusion, there of myocardial infarction. The electrocardiographic changes observed never involved the QRS complexes, but always involved the ST segments and T waves. These changes were always completely reversed in six weeks. More often than not, they were reversed in far less time. In none of these cases was there fever or leukocytosis.

In tabulating the electrocardiographic changes in our 19 cases, the following significant factors were noted: In no case was there significant elevation of the ST segment. In only 3 of the

19 cases was there significant depression of the ST segment. In 11 cases there was symmetric T wave inversion; in 3 cases, asymmetric T wave inversion. In 9 cases, diphasic T waves appeared, and in 9 cases there was a change from the upright to low and isoelectric T waves, which later became upright again. The time of reversion to normal was interesting. Of the 19 cases, in 14 there was reversion to normal within seven days, in most of them within five days. Reversion to normal occurred in 10 days in 1 case, in 11 days in 1 case, and in 3 it required six weeks.

Discussion

Of considerable surprise to us in our review of our tracings was the relative incidence of the various changes seen in this syndrome. We had expected to see ST depression as a predominant electrocardiographic feature. It is so cited by several authors.[2, 3] In only 3 cases of our series, however, was ST depression observed, and in none of these cases was it pronounced. The major changes noted were inversion of the T waves and the appearance of diphasic T waves, which later became upright. Why more ST changes were not demonstrated is unknown.

In view of the number of cases of this syndrome which we have encountered, we have attempted to come to some conclusions as to the meaning of these electrocardiographic changes in terms of pathologic physiology. It is probable that in many of these cases there is definite myocardial damage of the type reported by Horn, Field, Dack and Master[8] in their studies of the pathologic and physiologic aspects of acute coronary insufficiency. They reported a type of myocardial necrosis, which was limited in great part to the subendocardial musculature and to the papillary muscles of the left ventricle. These workers suggested that these lesions were characteristic of acute coronary insufficiency and represented myocardial alterations resulting from the discrepancy between the requirements of the myocardium and its available blood supply. Although there is a transient and reversible insufficiency of the coronary blood flow, the deleterious effects upon the myocardium may be permanent. In their series of 25 cases, the pathologic lesions of the myocardium, when grossly visible, generally consisted of isolated disseminated hemorrhagic or mottled yellow-gray or greenish discolored areas. The myocardial foci varied in size from discrete pinhead rather well delineated areas to wider and more irregularly bordered flame-shaped areas. Although the subendocardial musculature was predominantly involved, there was often a normal thin strip of muscle interposed between the endocardium and the affected portion. The extent and severity of the myocardial alterations appeared to vary with the duration and intensity of the predisposing precipitating factors which cause coronary insufficiency.

Although in some of our cases, especially those in which the electrocardiographic changes were of longer duration, there may have been myocardial necrosis of the type mentioned, there is some experimental evidence for the belief that in a number of these cases no myocardial damage may have resulted. This was most probable in those cases in which the electrocardiographic changes were not prolonged.

It has been shown that the cause of pain in coronary artery disease is myocardial ischemia. Gilson and Day[9] had 5 cases in which acute myocardial infarction was preceded by an ischemia phase, which could be determined clinically. They noted that the pain was maximal during the ischemia phase before the definite electrocardiographic evidence of infarction took place, and that the pain vanished after the infarction. We know also, from experimental work done by Bayley, LaDue and York,[10] that electrocardiographic evidence of myocardial ischemia can be produced experimentally in some circumstances by temporary occlusion of a coronary artery without any corresponding pathologic change. Blumgart, Gilligan and Schlesinger[11] noted that occlusion of a coronary artery in dogs for periods of five to 45 minutes might cause electrocardiographic changes which persisted for days to weeks. In these experimental animals they demonstrated no close relationship between the degree of electrocardiographic change and the magnitude of the myocardial lesion. The occurrence of these electrocardiographic changes could be related neither to the duration of the occlusion as produced in these experiments nor to the presence or the absence of infarction. Although 8 of 10 animals in which myocardial lesions developed showed electrocardiographic changes, 4 of the 8 dogs whose hearts were free from pathologic change showed similar electrocardiographic abnormalties. It is important in this connection to note that all the animals in which the occlusion was produced

showed changes in T waves and ST segments. Some of the dogs with definite electrocardiographic evidence of myocardial ischemia for as long as four or five days showed no evidence of myocardial damage, either macroscopically or microscopically.

In view of these findings, it is our belief that in some of these cases of intermediate coronary syndrome — that is, when there is pain of longer duration than one expects in angina, and when there are definite electrocardiographic changes which persist for no longer than one week and are not characteristic of myocardial infarction — it is possible that there are no definite changes in the myocardium, either in the subendocardium or elsewhere. In those cases, however, in which changes persist for more than one week, although not more than six weeks, it is highly probable that here there is definite myocardial damage, which is probably most commonly localized in the endocardium, as Horn and his co-workers[8] have shown.

A possible explanation for the persistent electrocardiographic changes without definite myocardial necrosis may be found in the work of Iseri and his co-workers.[12] They investigated the water and electrolyte content of myocardial and skeletal muscle obtained at autopsy in patients dying of acute myocardial infarction. They noted that in patients with recent myocardial infarction the infarcted myocardium showed a decided but proportionate increase in sodium chloride, and that there was a great reduction of potassium, magnesium and phosphorus, reflecting primarily losses from the injured myocardium. In the non-infarcted myocardium in these hearts, the five electrolytes gave values intermediate between the values obtained from infarcted segments and from normal controls. They suggested that it is possible that acute ischemia without necrosis could have been responsible for the chemical changes in areas beyond the gross infarct. In view of the known ability of electrolyte disturbances to cause electrocardiographic changes, especially of the nature usually present in acute ischemia, there is a good probability that the electrocardiographic changes seen in ischemia are mediated through electrolyte disturbances.

Summary

The incidence of intermediate coronary syndrome in a series of cases of acute coronary artery disease pain with positive electrocardiographic findings is reported. The characteristics of the electrocardiographic changes observed in these cases are presented. The possible correlation between the electrocardiographic and the pathologic changes is discussed.

References

1. Master, A. M., and Jaffe, H. L.: Complete Functional Recovery After Coronary Occlusion and Insufficiency, J. A. M. A. 147:1721-1726 (Dec. 29) 1951.
2. Master, A. M.; Jaffe, H. L.; Dack, S., and Grishman, A.: Coronary Occlusion, Coronary Insufficiency, and Angina Pectoris; Clinical and Post-Mortem Study, Am. Heart J. 27:803-816 (June) 1944.
3. Freedberg, A. S.; Blumgart, H. L.; Zoll, P. M., and Schlesinger, M. J.: Coronary Failure, Clinical Syndrome of Cardiac Pain Intermediate Between Angina Pectoris and Acute Myocardial Infarction, J. A. M. A. 138:107-114 (Sept. 11) 1948.
4. Graybiel, A.: The Intermediate Coronary Syndrome, Proceedings Second Biennial Postgraduate Cardiovascular Seminar, Florida Heart Association, 1952, p. 107.
5. Graybiel, A.: The Intermediate Coronary Syndrome, Transactions of the American College of Cardiology 1:60-88, 1951.
6. Littman, D., and Barr, J. H. Jr.: Acute Atypical Coronary Artery Insufficiency; Incidence and Clinical Course, Circulation 5:189-200 (Feb.) 1952.
7. Master, A. M., and Jaffe, H. L.: Factors in Onset of Coronary Occlusion and Coronary Insufficiency, Effort, Occupation, Trauma, and Emotion, J. A. M. A. 148:794-798 (March 8) 1952.
8. Horn, H.; Field, L. E.; Dack, S., and Master, A. M.: Acute Coronary Insufficiency; Pathological and Physiological Aspects; Analysis of 25 Cases of Subendocardial Necrosis, Am. Heart J. 40:63-80 (July) 1950.
9. Gilson, J. S., and Day, C. M.: Observations on Relationship of Pain to Process of Myocardial Infarction, as Shown by Electrocardiographs in "Latent" Cases, Ann. Int. Med. 38:470-477 (March) 1953.
10. Bayley, R. H.; LaDue, J. S., and York, D. J.: Electrocardiographic Changes (Local Ventricular Ischemia and Injury) Produced in Dog by Temporary Occlusion of Coronary Artery, Showing New Stage in Evolution of Myocardial Infarction, Am. Heart J. 27:164-169 (Feb.) 1944.
11. Blumgart, H. L.; Gilligan, D. R., and Schlesinger, M. J.: Experimental Studies on Effect of Temporary Occlusion of Coronary Arteries; Production of Myocardial Infarction, Am. Heart J. 22:374-389 (Sept.) 1941.
12. Iseri, L. T., and others: Water and Electrolyte Content of Cardiac and Skeletal Muscle in Heart Failure and Myocardial Infarction, Am. Heart J. 43:215-227 (Feb.) 1952.

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A New Rapid Method for Stomach-Cancer Diagnosis: The Gastric Brush. By J. Ernest Ayre, M.D., and Benjamin G. Oren, M.D. Cancer 6:1177-1180 (Nov.) 1953.

Apparently, the low calcium content of malignant cells is responsible for the tendency of malignant epithelial cells to separate more readily than normal epithelial cells. A gastric brush devised by the senior author exploits this principle of tumor friability, for even light contact of the rotating brush against the tumor removes great numbers of the cancer cells, while contact with normal healthy tissues yields lesser numbers of benign cells. This rotating brush in a sleeve, which may be passed with ease into the empty stomach of any patient during a five to 10 minute period, puts a simple and practical instrument at the disposal of the medical profession for the collection of gastric cells for study.

The authors present this instrument as a simple practical tool possessing the potential for screening for stomach cancer as an office procedure. It offers a new method of obtaining fresh, well preserved cells for diagnostic study, but they observe that studies of cells from scores of cases must be made in conjunction with other diagnostic methods to prove the accuracy of the cell-brush method to detect cancer in an early stage. At the present stage, however, the stomach brush (Ayre) seems to have definite possibilities of achieving diagnosis at a more favorable stage than most pre-existing methods.

Fenestration Operation Analyzed for Nonfenestrating Otologist; Experiences with 445 Fenestrations. By J. Brown Farrior, M.D., Richard A. Bagby, M.D., and Cecil Thomas, B.Sc., M.D., B.Ch. A. M. A. Arch. Otolaryng. 59:1-17 (Jan.) 1954.

The nonfenestrating otologists are described as the supreme court judges of fenestration surgery. There are many problems in which they have the great responsibility of advising the patient. To answer these problems from the selection of cases to the permanent hearing results is the goal of this presentation. The various aspects of the subject are discussed in detail for the benefit of the nonfenestrating otologist, and advice is also offered to the otosclerotic patient who is a candidate for a fenestration operation, covering the usual questions about the cause of his deafness, what the operation does, and the expected results.

The authors observe in conclusion: The primary results of the fenestration operation are dependent largely on the quality of the patient's bone conduction. The convalescence from the fenestration operation is usually pleasanter or less unpleasant than that after other major surgical operations. The nuisance sequelae of fenestration surgery are largely dependent upon surgical technic, after-care, and the emotional stability of the patient. Significant permanent undesirable sequelae are extremely rare. Properly performed, the fenestration operation is relatively free from serious operative risks. The permanent patency of the fenestra and the permanent restoration of hearing are dependent solely upon the microscopic perfection of the surgical technic.

Acute Fulminating Enterocolitis Following the Use of Antibiotics. By John R. Butter, M.D. South. M. J. 47:224-226 (March) 1954.

In this discussion of the lack of action of the antibiotics on a group of bacteria, the author observes that Micrococcus pyogenes var. aureus (formerly called Staphylococcus aureus) was initially, apparently, everywhere, sensitive to the antibiotics such as Terramycin, Aureomycin, streptomycin and chloramphenicol. Now, however, after the passage of time, many strains are capable of growing and multiplying in an environment formerly lethal to them. He reviews the change in the incidence of resistant M. pyrogenes and also the frequency of occurrence of Micrococcus enterocolitis as reported in the literature. Also, he explains that the colitis caused by this organism is due to the toxin produced by the large numbers of cocci growing in the intestine where the competing bacteria have been destroyed by antibiotics. After describing the symptoms, he states that treatment consists of prompt discontinuance of the antibiotic being used and, at present, the administration of erythromycin. Reports of 2 cases of acute fulminating enterocolitis following the use of antibiotics are illustrative.

Relationship between Cerebrospinal Fluid Pressure Changes and Cerebral Blood Flow. By M. Rich, M.D., P. Scheinberg, M.D., and M. S. Belle, M.D. Circulation Research 1:389-395 (Sept.) 1953.

Studies of the effects on the cerebrospinal fluid pressure were made by the authors with the following drugs, gas mixtures, and stimuli: nicotinic acid, procaine, Priscoline, papaverine, aminophylline, 5 and 10 per cent carbon dioxide, 100 per cent oxygen, 3 per cent sodium bicarbonate, and hyperventilation. These studies corroborate previous conclusions that alterations in cerebral blood flow are reflected by similar changes in the cerebrospinal fluid pressure in the same direction. The hypothesis is advanced that the elevations and depressions in cerebrospinal fluid pressure are due to the respective increased and decreased volume of the vascular structures of the brain, expanding within its rigid container.

Curability of Scleroma. By A. R. Hollender, M.D., F.A.C.S., and Henry M. Scheer, M.D., F.A.C.S., F.I.C.S. J. Internat. Coll. Surgeons 21:24-29 (Jan.) 1954.

Scleroma is defined as a chronic granulomatous disease of the mucous membrane of the upper part of the respiratory tract, probably caused by Klebsiella rhinoscleromatis. The main purpose of this article is to direct attention to the curability of scleroma, and, incidentally, to emphasize the more essential aspects of the disease in the light of present knowledge.

In summary, the authors observe that scleroma is a distinct entity with serious implications and is of special interest to pathologists and rhinolaryngologists alike. During the past 20 years the incidence of the disease in native Americans has been on the increase. There are reasonable grounds for the assumption that both a virus and K. rhinoscleromatis are implicated in the causation of scleroma, but until a virus is demonstrated, K. rhinoscleromatis must be regarded as the offending organism. Though some authors have attempted to classify scleroma into stages, it is not feasible to do so because the divisions lack definition and overlap each other.

Up to now the only procedure affording a measure of benefit in arresting the progress of scleroma has been roentgen irradiation. Two cases are reported in which successful results in 2 adult patients with scleroma add positive support to the claims of other clinicians that the disease now can be regarded as curable, and that until experience with other antibiotics is recorded, streptomycin is the one of choice.

Osteitis Pubis Treated with Cortisone. By James J. Nugent. J. Urol. 70:940-942 (Dec.) 1953.

Osteitis pubis is an extremely painful disease for which there has been no satisfactory treatment. A case of this disease is presented in which cortisone was used in treatment, and it is hoped that other observers will report their results in order that the true value of cortisone in osteitis pubis may be obtained. In adequate dosage, cortisone gave considerable relief of pain in this case; in inadequate dosage, it gave almost no relief of pain. It was concluded that cortisone did not apparently change the course of the disease in this case.

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The Physician's Heritage

The Christmas Season is the time when, traditionally, each of us pauses at least for a day to give thanks for the only Perfect Life that was ever lived. It should be, as well, a time for soul searching along with rejoicing, a period for evaluating what we are, what we have done, and what we can do to make our lives more like His. And for physicians, in particular, Christmas can well be an opportunity to think upon an aspect of our art too often forgotten in the busy round of practice and organizational activities, the glorious heritage of the physician from earliest times and the obligations inherent in that heritage.

No other profession can claim roots that reach so far back into the history of man as does medicine. The bones of prehistoric animals show that there was disease on earth even before Neanderthal Man appeared. And as long as men have walked erect, some among them have dared to treat the ills of others. The witch doctor of primitive tribes, muttering his incantations, was using some of the technics of modern psychiatry and psychoanalysis. And the first man who dared scrape a hole in his brother's skull with a flint knife was quite definitely the ancestor of today's brain surgeon. Ancient papyrus records from Egypt show a very highly developed medical and surgical profession more than five thousand years ago.

"He is the flower (such as it is) of our civilization," said Robert Louis Stevenson of the physician, "and when that stage of man is done with and only remembered to be marveled at in history, he will be thought to have shared as little as any in the defects of the period and most notably exhibited the virtues of the race. Generosity he has, such as is possible to those who practice an art, never to those who drive a trade; discretion tested by a hundred secrets; tact tried in a thousand embarrassments; and what is more important, Heraclean cheerfulness and courage. So it is that he brings air and cheer into the sickroom and often enough, though not so often as he wishes, brings healing."

Those of us who were taught during our formative medical years to have a deep and warm pride in the heritage of the physician have never lost it. With so much to teach in so little time, however, modern day medical education all too frequently

fails to inculcate into the young physician of today an appreciation for what it really means to be a doctor.

More particularly, physicians in general tend much too often to drift away from the obligations that go with being a doctor and a member of a noble profession with roots in remote antiquity. For there is a real obligation, and not only the conventional idealistic one of serving our fellow man without recompense if necessary. It is the obligation of leadership.

Physicians must be intelligent—medical schools quickly separate the wheat from the chaff. And they must be capable of a broad viewpoint from which to regard man and his ills, both physical and social, for medicine is no longer a matter of treating disease and ignoring the person. Because of this latter quality, physicians are peculiarly fitted for leadership in every walk of life, especially in a time when men are ruled more often by emotions and fears than by logic and concern for their fellows.

If we have let the duties of our profession, the obligations of social and financial success, and the very understandable desire for security blind us to these obligations of leadership in a time when it was never more badly needed, then it behooves us at Christmastime to pause for at least an hour or two and take stock. No other profession has the fine heritage and glorious traditions that ours has. Our Christmas prayer might well be that we be given the strength and the courage to live up to the obligations that go with it.

Frank G. Slaughter

Editor's Note: Dr. Frank G. Slaughter of Jacksonville is an internationally known author of fiction and medical nonfiction publications.

The Malpractice Insurance Problem

The subject of malpractice insurance is one which is being discussed by physicians throughout the state with much heat and little understanding. A number of questions are being asked: Why all the turmoil about malpractice insurance? Why these outlandish rate increases? What justification exists for such arbitrary action on the part of the insurance companies in canceling out policies and in insisting on tying in malpractice insurance with other types of insurance? Because the answers to these questions have not been readily apparent, the Florida Medical Association has been studying this problem for the past several years, trying to find a satisfactory solution. Although no completely satisfactory conclusion has been reached, it is believed that the results of the investigation should be brought to the attention of each member of the Association. With this idea in mind there begins in this issue of The Journal the first in a series of articles dealing with malpractice insurance. Your attention is invited not only to the first editorial in this series here presented but to each of three succeeding editorials which will appear monthly in these columns.

In August 1952 a subcommittee to the Board of Governors to study various aspects of insurance affecting physicians was directed by the Board. The members of this committee, with Dr. Samuel M. Day, Secretary-Treasurer, as chairman included Drs. Collin F. Baker Jr., Tampa; John P. Ferrell, St. Petersburg; Robert E. Zellner, Orlando; DeWitt C. Daughtry, Miami; and Dale E. York, Pensacola. Increasing rates for professional liability insurance led the committee into an extended study of this type of insurance. In April 1954 the subcommittee was discontinued and the assignment turned over to the standing Committee on Medical Economics, Robert E. Zellner, chairman. Other members of this Committee are: Drs. William H. Walters Jr., Lacoochee; William C. Roberts, Panama City; J. Maxey Dell Jr., Gainesville; and DeWitt C Daughtry, Miami.

—Editor

I. Why the Increase in Malpractice Insurance Rates in Recent Years?

The plain and simple fact is that we are living in a suit-happy age populated to a great extent by people looking for something for nothing. There is the man who asks his doctor, "Can't you say these x-rays were taken at the hospital so my insurance will pay for them?" or "Doctor, if you will just say on this blank that I have to call you at all hours of the night, I will be able to get a telephone. The telephone company won't know the difference," or "Doctor, you can charge extra for this since I've got insurance." This same fellow can rationalize with ease, suing his doctor for some imagined injury because "After all, he's got insurance!" During the decade between 1930 and 1940, the incidence of malpractice claims increased tenfold. Statistics compiled during the next 10 years are of less value for comparative purpose because of the disruption of the war years, but during the first three years of this decade the rate of increase established in the thirties has been maintained. So the answer to the first question as to why our malpractice insurance rates have increased is simple: The number of suits per doctor has reached an all time high until in one state the average in 1952 was one suit per 30 doctors insured.

What can be done to reverse this trend? Our answer to this question will appear in the next issue of The Journal.

FMA Executive Office Personnel Job Analysis

In the business world the term 'job analysis' is a familiar expression these days. Recently, it was given practical application in the Central Office of the Association. A memorandum from the Managing Director and Managing Editor of The Journal sent the office personnel scurrying to their typewriters to carry out the surprise assignment of preparing a detailed analysis of their individual duties. The task gave each member of the staff a broadened perspective on his own duties and responsibilities and a keener perception of his place and importance as a factor in the progress and success of the Executive Office organization as a whole.

Relatively few members of the Association have occasion to visit the headquarters of the Association, and consequently, few have the opportunity to observe the wheels in motion. It is regrettable that every member does not have a chance to appraise for himself the administrative organization which functions smoothly and efficiently from the Executive Office of the Managing Director-Managing Editor down through the Central Office and the Bureau of Public Relations to the Journal and Administrative Divisions.

How many members ever wonder about the Association's headquarters operations? The staff sometimes ponders that question for there are some within the membership who seem to have a nebulous idea indeed of what keeps the wheels turning. Just how is the staff organized? How does it operate? Who are the employees? To familiarize the members with the operational setup of the Executive Office, an outline was recently mailed to each member which represents a summary of the job analysis survey and includes two charts. This presentation answers all these questions and merits careful perusal by every member of the Association. It traces the operational activity from the House of Delegates and the Board of Governors down through the Executive Office to the detailed services of the Central Office with its Journal and Administrative Divisions and its Bureau of Public Relations with its Public Relations and Legislation Divisions. The members who keep abreast of how their Association operates are constantly apprised of how best it may serve them individually and collectively through the many channels of its varied activities.

Fee Schedule Cooperation

The Florida Medical Association has made phenomenal progress and won a commanding place for itself down through the years because it has had wise and able leaders devoted to their profession. It also has been blessed with loyal and cooperative members willing to keep local aspirations, and in some instances individual desires and preferences, subservient to the good of the Association and the medical profession as a whole.

As a result, the Association has been able to meet in forthright manner the problems that have arisen incident to progress and broader service. From time to time, as occasion has required, it has formulated policies based upon sound workable principles. These policies have not been hastily made. After due deliberation, often entailing great expenditure of time and effort on the part of its official representatives, decisions have been reached that have protected and promoted the best interests of all the members.

Fee schedules offer a case in point. The recently consummated task of investigating, weighing and negotiating this matter was carried out over a period of years with diligence and unremitting effort by those to whom the difficult undertaking was committed. The resulting complete revision of the Veterans Administration Fee Schedule and the Industrial Commission Fee Schedule, revision of the Fee Schedule for Blue Shield, and acceptance by the Medical Advisory Committee to Vocational Rehabilitation of the new Fee Schedule of the Veterans Administration as a guide, represented an accomplishment heralded as a great step forward which got away from the fixed fees of 15 to 20 years ago. Certainly the great majority of the Association's members who engage in compensation practice did not object to the agreed fee schedules and have adhered to them even though some may not have considered certain fees adequate.

The individual member who fails to abide by the Association's adopted policy in a matter of this sort disregards the ethical standpoint involved in breaching an agreement made by the Association. Thereby he brings discredit to the Association in its relations with industry, and his action has far reaching unfavorable effect upon public relations. Such an attitude invites other members to do likewise and could promote a trend that would wreck the established policies of both the Association and the Industrial Com-

mission and other organizations entering into the agreements.

Amicable relations arrived at after careful deliberations over a long period of time by competent representatives are to be prized and fostered rather than undermined, disrupted and perhaps eventually shattered because of lack of cooperation on the part of a few. It would seem that any member of an organization of the caliber of the Florida Medical Association would be glad to cooperate in this matter or, if unwilling, then would be willing to desist from compensation practice so long as he maintains affiliation with organized medicine within the state. If obviously exceptional instances arise, he is always free to negotiate directly with the organization involved in order to arrive at a mutually satisfactory fee. Certainly that is the procedure to be followed rather than to seek an additional fee from the patient. With understanding of all that is involved, surely to any reasonable member concurrence in the position taken by the Association and in the agreements it has made would be a privilege affording ample compensation for the sacrifice of a few dollars, and even a personal opinion or desire, in order that the good of the entire Association and the medical profession as a whole may be served.

The benefits accruing to the members from affiliation with the Association are too obvious and too numerous to be mentioned here. The members avail themselves of these benefits gladly and even take them for granted. It is to be presumed then that no member would care to practice medicine in Florida without this organization and its benefits any more than he would without schools and churches and stable government with their multitudinous benefits. In that event, full cooperation is not too much to ask and to expect. It represents democracy at its best in a free land where liberty is never license for the few.

Russians Move In on the ILO

Efforts of the International Labor Organization to point this country in the direction of socialized medicine have been discussed editorially in The Journal as long ago as October 1952 and as recently as August 1954. Socialism by treaty is no more palatable to the people of this country than socialism by domestic legislation, and to ward off the danger of such commitment by the insidious approach of ILO conventions, or treaties, requires constant vigilance under present laws in this country.

The activities of the ILO have long commanded the keen interest of the American Medical Association because of its covenants embracing sickness benefits and compulsory health insurance. It now transpires that the Russians have moved in on ILO. Reporting on the 37th International Labor Conference of the ILO held in Geneva last June, Mr. William L. McGrath of Cincinnati, Employer Delegate to this annual meeting, pointed out that the Russians had dropped out in 1939, but their readmission was automatic on their request since the revised constitution of the ILO admits any country which is a member of the United Nations and which agrees to abide by the ILO constitution.

This observer contends that with the admission of Communist "employer" and "worker" delegates, the basic premise upon which the ILO was founded has been violated. Despite the problem occasioned by the spread of nationalized industries in socialist countries, until now worker, employer and government delegates from practically all the countries represented in the ILO, except Poland, Czechoslovakia and one or two others, had been free to express their divergent views. With official acceptance of the premise "that a government man, acting under government orders, can qualify

ARE YOU MOVING?

Please send the following to: Florida Medical Association, P. O. Box 1018, Jacksonville, Fla.

Name _____
(Please print)

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Street _____
City & Zone _____
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City & Zone _____
State _____

as an 'employer' delegate" and likewise "that a government man, acting under government orders, can serve as a 'worker' delegate," it follows, as Mr. McGrath observed, that ILO "has officially ruled that 'freedom of association' is not a prerequisite of membership."

The ILO originally was founded on the basis that worker delegates would represent free trade unions whose membership was determined on a voluntary basis, and that employer delegates would represent associations of free employers, also joined together on a voluntary basis. In the opinion of Mr. McGrath, "the abandonment of these basic principles destroys . . . the underlying foundation of the ILO." Here is another straw in the wind signaling danger in ILO, which should have more than passing interest for physicians in this country.

"Athlete's Heart" a Myth

Athletes have good hearts. The common impression to the contrary is not borne out by recent research. The belief that champion athletes, upon reaching middle age, have enlarged hearts and are likely to meet early death from heart disease is proved false by a study made by Dr. Thomas K. Cureton of the Physical Fitness Research Laboratory of the University of Illinois.[1] This former national champion in swimming compared the results of some 128 tests on 55 former athletic champions in seven nations with those of identical tests made on nonathletic middle-aged and young men.

The investigation disclosed that when the champion athlete deteriorates physically in middle age, the cause is not earlier excessive athletic activity. It is rather that after winning his title, he lapses into sedentary life and indulges in subsequent excesses in eating, drinking and smoking, thereby undermining the magnificent physique that his athletic training has built up. The champions who have kept active are superior physically to the average middle-aged man.

The average former champion tested in this study won his title 10 years ago and is now about 45 years of age. He has broader shoulders, narrower hips, less "bay window," stronger hands and better feet than his nonathletic counterpart. He is stronger, has more powerful legs and back, has greater strength in proportion to his weight, is more agile and has better muscular endurance. Too, he has a more efficient heart and blood circulation. In addition, he has greater tolerance of stress and in general is more ready for action, psychologically and physiologically.

The former champion weighs more than the nonathletic young man, but about 5 pounds less than the nonathlete of his own age. His extra weight is, for the most part not fat. He is more solid than the others.

The tests were confined to individual athletes, excluding baseball, basketball and football players, whose sports activity is seasonal. Different sports develop different parts of the body, with middle distance runners and swimmers having the broadest chests. Swimmers also have the greatest shoulder and hip width and chest depths, but more fat than these runners. Chest expansion is 3.90 inches for the gymnasts, 3.75 inches for the swimmers and 3.25 inches for the sprinters and hurdlers. The swimmers have the fastest reaction times and best breath-holding times, along with the poorest foot arches.

Dr. Cureton believes that the middle-aged man who has led a sedentary life safely can and should begin to exercise. Appropriate mild exercise can prove surprisingly beneficial to the older man who desires to recondition himself when he conscientiously keeps up his exercise regularly, working alone and in moderation. This investigator concludes that a regular program of physical exercise adhered to by persons in their forties and fifties not only would lengthen life, but would also decrease deaths from heart disease in men and women in the prime of life.

1. Van de Water, M.: Athletes Have Good Hearts, Science News Letter 66:10-11 (July 3) 1954.

Congratulations on Emory Centennial Number

The Journal is pleased to offer congratulations to its next door neighbor, The Journal of the Medical Association of Georgia, on its Emory University School of Medicine Centennial Number (September 1954). From the salute to Emory on the President's Page through the editorial in the form of "A Case History" on the 100 year old patient by Dr. Ted F. Leigh, Guest Editor, and "The First Hundred Years," a chronological account of the school's development, this fitting tribute continues with "Interview—with R. Hugh Wood, M.D., Dean, Emory University School of Medicine: The Dean's Job" and articles entitled "Facilities of Emory University School of Medicine" and "Research in Emory University School of Medicine."

The concluding article in the Special Emory Section entitled "Reminiscences of an Old Grad" covers the recollections of Dr. Robert L. Whipple of Cochran, Ga., a graduate of the class of 1896. Now an octogenarian who has practiced continuously for 58 years in his home town, he related memorable experiences of his medical school days for this article against a backdrop of an old fashioned roll top desk stuffed with papers accumulated over the years, recently installed air conditioning and a waiting room full of patients.

The Centennial celebration took place on October 4 and 5. The program featured medical addresses by a select group of distinguished speakers: Dr. Alfred Blalock, Professor of Surgery, The Johns Hopkins University; Dr. John F. Fulton, Professor of Physiology and Professor of the History of Medicine, Yale University; Dr. Stanhope Bayne-Jones, Director of Research of the Medical Department of the United States Army; Dr. Cyrus W. Sturgis, Professor of Medicine, University of Michigan; and Dr. Evarts A. Graham, Professor of Surgery, Washington University. The convocation address was presented by Dr. Alan Gregg, Director of Medical Sciences and Vice-President of the Rockefeller Foundation.

Said President Peter B. Wright in his President's Page message: "We, of the Medical Association of Georgia and citizens of this great state, salute Emory and wish to express our sincere gratitude for its contributions to Medicine and its favorable influence on the profession and the public. May its upward trend ever continue." The Journal and its Editors are happy to join in this salute on behalf of the medical profession and citizens of Florida, and they congratulate the Journal of the Medical Association of Georgia on its excellent coverage of this notable centennial occasion.

Midwinter Seminar in Ophthalmology and Otolaryngology Miami Beach, Jan. 17-22, 1955

For the ninth successive year, the annual University of Florida Midwinter Seminar in Ophthalmology and Otolaryngology will be held at Miami Beach. As for the past several years, the headquarters will be the Sans Souci Hotel. This outstanding graduate course attracts registrants each year from all parts of the nation and several foreign countries. The excellent program is always arranged to permit ample time for recreation. The dates this winter are January 17 through 22.

All registrants are invited to attend the Midwinter Convention of the Florida Society of Ophthalmology and Otolaryngology, which each year is a midweek feature. The 1955 meeting will be held on Wednesday afternoon, January 19, and there will follow at 8 p.m. the usual informal banquet, with an eminent guest speaker presenting an address. Seminar registrants and their wives are privileged to attend.

The Seminar lectures on Ophthalmology are scheduled for Monday, Tuesday and Wednesday, January 17, 18 and 19. The lecturers and their subjects are: Dr. James Allen, New Orleans, "Muscle Cone Implant Technique," "Anatomical Principles of Glaucoma Surgery" and "Basic Principles of Treatment of Infectious Diseases of the Eye;" Dr. Milton L. Berliner, New York City, "Role of Lamellar Resection in Retinal Detachment," "Experiences with Cyclodiathermy in Chronic Simple Glaucoma," and "Biomiscroscopy of the Vitreous;" Dr. Walter H. Fink, Minneapolis, "Vertical Oculomotor Problems," "Surgery of Vertical Acting Muscles, Indications and Technique" and "Ocular Vergence—Clinical Significance;" Dr. William F. Hughes Jr., Chicago, "Treatment of Keratitis," "Beta Radiation" and "Surgery of Retinal Detachment;" and Dr. Phillips Thygeson, San Jose, Calif., "Uveitis Syndromes," "Differential Diagnosis of Superficial Keratitis" and "Ocular Complications of the Dermatoses."

On Thursday, Friday and Saturday, January 20, 21 and 22, the lectures on Otolaryngology will be presented. The lecturers and their subjects are: Dr. Lawrence R. Boies, Minneapolis, "Current Problems in Otology," "Chronic Sinusitis" and "Head Pain;" Dr. David D. DeWeese, Portland, Ore., "Diagnosis, Prevention, and Treatment of Postoperative Atelectasis," "Control of Atypical Facial Pain" and "The Community Hearing Problem;" Dr. Edmund P. Fowler Jr., New York City, "Diagnosis and Treatment of Facial Paralysis," "Management in Menière's Disease" and "The Speech and Hearing Problems of Children;" Dr. Paul H. Holinger, Chicago, "Foreign Bodies in the Air and Food Passages," "Congenital Anomalies of the Larynx" and "Endoscopic Technics;" and Dr. Arthur W. Proetz, St. Louis, "Clinical Aspects of Nasal Air Currents," "Air-Conditioning" and "Brushing up on Displacement."

Medical District Meetings, 1954

Meetings were held this year in Marianna, October 11; Sanford, October 13; Vero Beach, October 14; and Sarasota, October 15. At these four meetings Association members had an opportunity to meet with their state officers and to discuss with them important state level activities. A new form of scientific program was held this year. In each district panel discussions were held on subjects met daily in most doctors' offices.

Dr. Francis H. Langley, chairman of Council, presided at both the scientific assembly and the general session of each of the four meetings.

Drs. Duncan T. McEwan, President; John D. Milton, President-Elect; and Samuel M. Day, Secretary-Treasurer, were present at all of the meetings and gave short talks. Dr. Shaler Richardson, Editor of The Journal, was present at the Marianna, Sanford and Vero Beach meetings and reported on the progress of The Journal this year.

Dr. H. Phillip Hampton, Chairman of the Committee on Legislation and Public Policy, spoke at the Sarasota meeting, and Dr. Edward Jelks, Public Relations Liaison to the Board of Governors, spoke at all four meetings.

A Medical District Meeting is not expected to attract a large attendance, since there is only one-half day and evening in the schedule. Those who attended were enthusiastic in their favorable comments, and Association officers appreciated the opportunity to meet new colleagues and renew old acquaintances.

Workshop meetings were arranged for the ladies by the Woman's Auxiliary under the leadership of Mrs. Richard F. Stover. Presiding were Mrs. William D. Rogers at the Marianna meeting; Mrs. Albert G. Love IV at the Sanford meeting; Mrs. Charles McD. Harris Jr. at the Lakeland meeting; and Mrs. John P. Ferrell at the Sarasota meeting.

Northwest Medical District

October 11 — Marianna

Dr. Francis H. Langley, chairman of Council, presided at the meeting and was assisted at the scientific session by Dr. William P. Hixon, councilor of District 1, and at the general session by Dr. George S. Palmer, Councilor for District 2.

Dr. Jabe A. Breland, president of the Jackson-Calhoun County Medical Society, gave the address of welcome as the meeting was called to order at 3:30 p.m.

Following the address of welcome, a panel discussion on "Common Emergencies" was presented with Dr. Sidney G. Kennedy Jr. of Pensacola discussing the surgical aspects; Dr. William C. Fontaine of Panama City, the obstetric and gynecologic aspects; Dr. Barkley Beidleman of Pensacola, the medical aspects; and Dr. Alvyn W. White of Pensacola, the pediatric aspects.

State officers gave short talks during the general session.

Refreshments and dinner were served by the host society.

The 1955 meeting will be in Pensacola. Total registration was 61, of which 49 were Association members (A District 42) and 12 visitors. Among those registered were past presidents Julius C. Davis, Herbert L. Bryans, Edward Jelks, Shaler Richardson and Walter C. Payne Sr.

Registration

ALTHA: Jasper B. Dowling. BLOUNTSTOWN: Grayson C. Snyder. CHATTAHOOCHEE: William D. Rogers. GRACEVILLE: William W. Richardson. JACKSONVILLE: Samuel M. Day, Edward Jelks, James G. Lyerly, Nelson A. Murray, Shaler Richardson. MARIANNA: Jabe A. Breland, James T. Cook Jr., Henry I. Langston, Albert E. McQuagge, Sarah M. Schulz, William R. Wandeck, Francis M. Watson. MIAMI: John D. Milton. ORLANDO: Duncan T. McEwan. PANAMA CITY: John J. Benton, Jack Corbitt, William C. Fontaine, William F. Humphreys Jr., William C. Roberts, Roderick C. Webb. PENSACOLA: Constantine A. Asters, Barkley Beidleman, Herbert L. Bryans, Francis P. Cassidy, John R. Emlet, Samuel D. Gillespie Jr., William P. Hixon, Sidney G. Kennedy Jr., John J. McGuire, John C. McSween, Allen L. Miller Jr., William W. Miller Jr., Walter C. Payne Sr., Walter C. Payne Jr., Vernon L. Smith, Alvyn W. White. QUINCY: Julius C. Davis. ST. PETERSBURG: Francis H. Langley. TALLAHASSEE: Merritt R. Clements, George H. Garmany, Francis T. Holland, John L. Lincoln, George S. Palmer, Luther L. Pararo Jr., Henry L. Smith Jr.

VISITING DOCTORS — GRAHAM AIR BASE: Q. R. Johnson Jr. PANAMA CITY: Lloyd B. Harrison Jr. PENSACOLA: R. V. Berry, Herman S. Shapiro, Earl M. Spaulding. TALLAHASSEE: Nelson H. Kraeft, George I. Lebess, George H. McCain, Earl E. Wilkison.

OTHER GUESTS — JACKSONVILLE: Ernest R. Gibson, W. Harold Parham, H. A. Schroder.

Northeast Medical District

Sanford — October 13

The meeting was held at the Mayfair Inn with Dr. Henry J. Babers Jr., councilor of District 3, presiding with Dr. Langley at the scientific assembly, and Dr. Thomas C. Kenaston, councilor of District 4, assisting at the general session.

At 2:30 p.m., members and guests were welcomed by Dr. J. Clifford Boyce, president of the Seminole County Medical Society.

The panel discussion at this meeting was on "Office Procedure." Participants and their subjects were Drs. Truett H. Frazier, Orlando, Urology; Edward P. Madden, Daytona Beach,

Gynecology; Leila H. Wells, Jacksonville, Laboratory; and Alva T. Cobb Jr., Gainesville, Use of Hydrocortone.

Short talks of statewide interest were presented by the state officers present. Refreshments and a barbecue were served by the host society.

At the general session, Gainesville was selected as the meeting place for 1955. Total registration was 103, of which 93 were Association members (B District 91) and 10 visitors. Among those registered were past presidents Edward Jelks, Shaler Richardson and Robert B. McIver.

Registration

APOPKA: Thomas E. McBride. COCOA: Thomas C. Kenaston, A. F. Thomas. DAYTONA BEACH: John J. Cheleden, James W. Clower Jr., C. Robert DeArmas, Herbert A. King, Edward P. Madden, James D. Moffett Jr., Achille A. Monaco, Norman E. Williams. DELAND: Lancaster C. Starke (Col.). DUNNELLON: Bertrand F. Drake. EUSTIS: Matthew Arnow, Rabun H. Williams. GAINESVILLE: Edwin H. Andrews, Henry J. Babers Jr., Alva T. Cobb Jr., Henry H. Graham, Albert G. Love IV, George H. Putnam. HOLLY HILL: Frank A. Sica. JACKSONVILLE: S. James Beale, C. Ashley Bird, Frederick H. Bowen, J. Brooks Brown, Robert J. Brown, Samuel M. Day, Lucian Y. Dyrenforth, A. Judson Graves, Vernon T. Grizzard Jr., Ivan Isaacs, Edward Jelks, F. Gordon King, Robert B. McIver, Bernard L. N. Morgan, Thad Moseley, Nelson A. Murray, Shaler Richardson, C. Burling Roesch, Wilson T. Sowder, John T. Stage, J. Champneys Taylor, William A. Van Nortwick, Carl H. Wells, Leila H. Wells, Ashbel C. Williams. MIAMI: John D. Milton. OCALA: William H. Anderson Jr., Eugene G. Peck Jr. ORLANDO: James L. Campbell Jr.., J. Rocher Chappell, Chas. J. Collins, Horace A. Day, Robert P. Henderson, David Y. Hicks Jr., Albert C. Kirk Sr., Duncan T. McEwan, James A. McLeod, J. William Martin, Fred Mathers, William S. Mitchell, Isidore Pincus, George P. Shanck Jr. (Col.), Charles R. Sias, W. Dean Steward, Robert L. Tolle, Truett H. Frazier. OVIEDO: Edward W. Stoner. PALATKA: Grover C. Collins. ST. AUGUSTINE: Donald T. Rankin. ST. PETERSBURG: Francis H. Langley. SANFORD: Orville L. Barks, Terry Bird, J. Clifford Boyce, Edwin Epstein, Wade H. Gardner, Thomas F. McDaniel, Daniel H. Mathers, John M. Morgan, Leonard Munson, Charles L. Park Sr., Charles L. Park Jr., William V. Roberts, Freddie A. Smith (Col.), James A. Smith, Gordon D. Stanley, George H. Starke (Col.). TAVARES: J. Basil Hall. WINTER GARDEN: Edward Bradford, Albert H. Gleason. WINTER PARK: Robert E. Drake, Simeon M. Wrenn.

VISITING DOCTORS — DAYTONA BEACH: Frederick C. Andrews. JACKSONVILLE: James E. Cousar III. WINTER PARK: Harry W. Benson, James A. Ford. ATLANTA, GA.: H. J. Crider Jr. HENDERSON, N. C.: Harry Z. Silsby. BELGIAN CONGO: William S. Hughlett.

OTHER GUESTS — JACKSONVILLE: Ernest R. Gibson, W. Harold Parham, H. A. Schroder.

Southeast Medical District

Vero Beach — October 14

Presiding with Dr. Langley at the scientific assembly was Dr. Russell B. Carson, councilor of District 8. Dr. James R. Sory, councilor of District 7, assisted Dr. Langley in presiding at the general session.

Dr. William L. Fitts 3rd, president of the Indian River County Medical Society, gave the address of welcome.

"Business Office Management" was the title of the panel discussion held at this meeting. Participants were Drs. Laurie R. Teasdale, West Palm Beach; Lees M. Schadel Jr., Fort Lauderdale; and M. Jay Flipse, Miami.

Officers of the Association presented talks of interest during the general session. Refreshments and dinner were served by the host society.

The 1955 meeting will be held in Fort Lauderdale. Total registration was 61, of which 50 were Association members (D District 43) and 11 visitors. Among visitors attending the meeting were past presidents Edward Jelks, Shaler Richardson and Robert B. McIver.

Registration

DANIA: Fred E. Brammer. FORT LAUDERDALE: Alfred E. Cronkite, Burns A. Dobbins Jr., Scottie J. Wilson. FORT PIERCE: John D. Browning, Alfred J. Cornille, Hugh B. Goodwin Jr., John T. McDermid, Robert F. Meeko, Adrian M. Sample, Richard F. Sinnott. HIALEAH: Albert W. McCorkle. JACKSONVILLE: Samuel M. Day, Edward Jelks, Robert B. McIver, Shaler Richardson. LAKE WORTH: A. Scott Turk. MIAMI: Reuben B. Chrisman Jr., Edward W. Cullipher, M. Jay Flipse, John D. Milton, Homer L. Pearson Jr. ORLANDO: J. Cornall Howarth, Duncan T. McEwan. ST. PETERSBURG: Francis H. Langley. VERO BEACH: William L. Fitts 3rd, Vernon L. Fromang, John P. Gifford B. Bowman Guerin, Erasmus B. Hardee, Kip G. Kelso, P. T. McClellan, James C. Robertson. WEST PALM BEACH: Willard F. Ande, James R. Anderson, John M. Baber, Joseph J. Daversa, Lorenzo James, Edgar A. P. Kellerman, W. Ambrose McGee, Theodore Norley, Ralph M. Overstreet Jr., Cecil M. Peek, Raymond R. Preefer, Atwell B. Pride (Col.), Raymond S. Roy, William Y. Sayad, Vitol S. Shepard, James R. Sory, Laurie R. Teasdale.

VISITING DOCTORS — FORT LAUDERDALE: James F. Berry, R. K. Haugen, Lees M. Schadel Jr. WEST PALM BEACH: James F. Cooney, Philip O. Lichtblau, Governor M. Witt. PHILADELPHIA, PA.: William C. Thoroughgood.

OTHER GUESTS: JACKSONVILLE: Ernest R. Gibson, W. Harold Parham, H. A. Schroder. MIAMI: John C. Lee.

Southwest Medical District

Sarasota — October 15

Dr. James R. Boulware Jr., councilor of District 6, assisted Dr. Langley in presiding at the scientific assembly, and Dr. Clyde O. Anderson, councilor of District 5, presided with Dr. Langley at the general session.

Dr. Henry J. Vomacka, president of the Sarasota County Medical Society, welcomed the members and guests.

Dr. N. Worth Gable of St. Petersburg was moderator for the panel discussion. Members of the panel and their subjects were Drs. Jere W. Annis, Lakeland, "Heart Problems;" C. Frank Chunn, Tampa, "Minor Surgery;" Woodrow B.

Estes, St. Petersburg, "Gynecology;" and Luverne H. Domeier, St. Petersburg, "Laboratory and Office Management."

Association officers present gave short talks of statewide interest at the afternoon general session.

Refreshments and a barbecue were served by the host society.

The 1955 meeting place chosen at the general session is Lakeland. Total registration was 94, of which 85 were Association members (C District 79) and 9 visitors. Past presidents in attendance were Edward Jelks, David R. Murphey Jr., and Robert B. McIver.

Registration

ANNA MARIA: Edgar W. Huth. ARCADIA: Harold S. Agnew, Gordon H. McSwain. AVON PARK: Hubert W. Coleman. BARTOW: Milo H. Holden. BRADENTON: Alfons R. Bacon, Lowrie W. Blake, Joseph A. Gibson, Richard V. Meaney, Millard P. Quillian, Sidney Smith. CLEARWATER: James V. Freeman, Robert L. Neil. DUNEDIN: John A. Mease Jr., James O. Norton, James F. Spindler. FORT MYERS: Ernest Bostelman, James L. Bradley, William H. Grace. JACKSONVILLE: Samuel M. Day, Edward Jelks, Robert B. McIver, Wilson T. Sowder. LAKELAND: Jere W. Annis, James P. Boulware Jr. LAKE WALES: Willard E. Manry Jr. MIAMI: John D. Milton. NAPLES: Ethel H. Trygstad, Reidar Trygstad. ORLANDO: Duncan T. McEwan. PUNTA GORDA: Walter B. Clement, Roscoe S. Maxwell. ST. PETERSBURG: Clyde O. Anderson, George H. Anderson, Luverne H. Domeier, Charles K. Donegan, Woodrow B. Estes, John P. Ferrell, N. Worth Gable, Douglas W. Hood, Francis H. Langley, Joseph W. Pilkington, Richard Reeser Jr., Joseph J. Regan, Franklin W. Roush Jr., John P. Rowell, Richard H. Sinden, Benjamin H. Sullivan. SARASOTA: Lester H. Blackburn, John M. Butcher, George M. Coggan, Francis M. Crage, Lloyd J. Duest, T. Vernon Finch, Thomas C. Garrett, Edmund P. Kelley, James E. Kicklighter, Cecil E. Miller, Arthur O. Morton, Robert O. Pitts, Hugh G. Reaves, Karl R. Rolls, Melvin M. Simmons, Henry J. Vomacka, Millard B. White, Reaves A. Wilson. SEBRING: Zaven M. Seron, Howard V. Weems Sr. TAMPA: Richard A. Bagby, Ernest R. Bourkard, Frank V. Chappell, C. Frank Chunn, Rosalind E. Cummings, Charles M. Gray, H. Phillip Hampton, Samuel G. Hibbs, James B. Hodge Jr., Warren T. Loftis Jr., Eugene B. Maxwell, David R. Murphey Jr., James N. Patterson, Wesley W. Wilson, James A. Winslow Jr. VENICE: Samuel E. Kaplan, Talmadge S. Thompson.

VISITING DOCTORS — BRADENTON: Eugene E. Biel. KEY WEST: William S. Hatt. ST. PETERSBURG: William J. Bailey, Francis Neumayer. SARASOTA: Samuel R. Warson. TAMPA: Robert H. Coffer Jr.

OTHER GUESTS — JACKSONVILLE: Ernest R. Gibson, W. Harold Parham, H. A. Schroder.

Graduate Medical Education

The Florida Clinical Diabetes Association held its second annual meeting at the San Juan Hotel in Orlando on Oct. 21-22, 1954. A seminar on diabetes and metabolic diseases was presented by the association in cooperation with the Department of Medicine of the Graduate School of the University of Florida, the Florida Medical Association and the Florida State Board of Health. Dr. Joseph T. Beardwood Jr. and Dr. H. B. Mulholland gave the clinical lectures and on Friday evening spoke before a lay audience. Papers by members of the Association were presented by Dr. Richard H. Sinden, Dr. Edward R. Smith, Dr. Turner Z. Cason and Dr. Joseph J. Lowenthal. Attendance by the general practitioners of the state was small, but many of the internists particularly interested in diabetes mellitus and other metabolic diseases were present. An unofficial request was received from the general practitioners to hold the next annual session either at the same time or immediately before the meeting of the Florida Academy of General Practice. The following officers were elected: Dr. Sidney Davidson, Lake Worth, President; Dr. Richard H. Sinden, St. Petersburg, President-Elect; Dr. Edward R. Smith, Jacksonville, Secretary-Treasurer; Board of Governors: District A, Dr. John J. Benton, Panama City; At Large. Dr. Joseph J. Lowenthal, Jacksonville, Dr. Francis D. Pierce, Fort Lauderdale and Dr. William P. Logan, Lakeland.

* * *

The Duval District Heart Association in cooperation with the Department of Medicine of the Graduate School of the University of Florida, the Florida Medical Association and the Florida State Board of Health will present a two day seminar on cardiovascular diseases on Thursday and Friday, Feb. 17-18, 1955 in Jacksonville. There will be four guest speakers, two of whom will be Dr. George T. Harrell, Dean of the College of Medicine, University of Florida, and Dr. Ashton Graybiel, Capt., U. S. Naval School of Aviation Medicine, Pensacola. The other two speakers will be announced shortly. This seminar is open to all physicians in Florida, and programs will be mailed out early in January.

The Editor Invites Your Contributions on Data of Notable Interest

American Medical Association
Atlantic City Meeting
June 6-10, 1955

The Council on Scientific Assembly announces the deadline for those who wish to participate in the Atlantic City meeting, either by reading a paper or presenting a scientific exhibit:

Deadline for Section Papers, Dec. 15, 1954

Deadline for Scientific Exhibit, Jan. 10, 1955

Applicants should communicate with the Secretary or the Representative to the Scientific Exhibit of the Section in which they are interested. Further information may be obtained from the Secretary, Council on Scientific Assembly, American Medical Association, 535 North Dearborn St., Chicago 10.

OTHERS ARE SAYING

Dr. Howard Rusk, New York, in a lecture befor the American Academy of General Practice — "Sick people ask their God, 'why must I suffer?' Possibly the answer is in the work of the potter. Fine ceramic pieces are not made by setting clay out in the sun. They come only from the white heat of the kiln. In the firing process some pieces are broken, but those that survive the heat are transformed from dull clay into objects of priceless beauty. And so it is with the sick, suffering, and crippled people. Those who, through medical skill, opportunity, work and courage, survive their illness or overcome their handicap, take their places back in the world with a depth of spirit which we can hardly measure."

—Secretary's Letter, July 27, 1954

Are Doctors Human?

Some years ago Robert Burns wrote:

"Oh wad some power the giftie gie us
"To see oursel's as others see us!
"It wad frae monie a blunder free us,
"And foolish notion."

Reportedly addressing the American Academy of General Practice,[1] a physician who was once an ordained minister criticized doctors "who feel that God made them, and everybody else just happened":

"Dr. Robert M. Myers, of Kansas City, made the remark in urging doctors to "become more human" in dealing with patients, especially prospective mothers. . . ."[2]

This comes with all the force of a one-two punch to the button, ministerial and medical. Admittedly our excerpt is only a portion of the address of the good doctor who reportedly was "once an ordained minister," but it has the virtue of brevity, the force of cloth and scalpel, and the saving grace of humor.

Reading the printed report of his address, we naturally reverted to the familiar lines of Burns which so many readers will recognize and so few remember as having been written to a louse. Burns's message as we interpret it was "Be yourself."

We think that doctors are human, and we believe that most people consider them so under trying circumstances, illness and despair, pain and worry. Only when they are well again do a few people cast about them for defects in the professional man and his service. We fail to comprehend how anyone can "become more human" than human. If "to err is human," does the good doctor's thesis call for more rather than less of this characteristic? His reported words could be so interpreted.

For our part, Burns to win, place, and show. Maybe we're just old-fashioned.

1. Cleveland, Mar. 24, 1954.
2. *Herald Tribune*, Mar. 25, 1954, p. 17.

—New York State Journal of Medicine, September 1, 1954

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. Joel Fleet of Jacksonville announce the birth of a daughter, Robin Elise, on Aug. 21, 1954.

Dr. and Mrs. Ashbel C. Williams of Jacksonville announce the birth of a son, Ashbel Cotten Jr., on Oct. 30, 1954.

Dr. and Mrs. Ray O. Edwards Jr. of Jacksonville announce the birth of a daughter, Ann Elizabeth, on Nov. 3, 1954.

Marriages

Dr. Jacob Neber and Mrs. Mabel Goff, both of Miami, were married on Aug. 22, 1954.

Deaths — Members

Gable, Nonie W., St. Petersburg	Oct. 9, 1954
Peyton, Harry A., Jacksonville	Oct. 17, 1954
Andrews, Mitchell M., Orlando	Oct. 20, 1954
Stinson, William M., Jacksonville	Oct. 24, 1954
Hebard, Charles E., Tampa	Nov. 10, 1954

Deaths — Other Doctors

Buss, Loring A., Orlando	June 28, 1941
Rouse, William O., St. Petersburg	March 29, 1944
Dower, Clancy M., Opa Locka	April 1, 1950
Jackson, Noah, West Palm Beach	July 29, 1950
Coupland, James D., Los Angeles, Calif.	Dec. 20, 1951
Whiteside, John McI., Lakeland	Dec. 27, 1951
Goodwin, Frederick P., Bloomington, Ill.	Feb. 11, 1952
Crigler, Wallace P., Tampa	March 2, 1954

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Colmer, William M. Jr., Pensacola
Jeffress, J. Elizabeth, Tallahassee
Leavenworth, William M., Jacksonville
Pararo, Luther L. Jr., Tallahassee
Sherman, Roger D., Warrington
Spaulding, Earl M., Pensacola
Tyor, Malcolm P., Jacksonville

EIGHTY-FIRST ANNUAL MEETING
FLORIDA MEDICAL ASSOCIATION
ST. PETERSBURG
APRIL 3-6, 1955

STATE NEWS ITEMS

Late this month the University of Florida will be host to the Gerontological Society, a national organization which will hold its seventh annual scientific meeting in Gainesville on December 28, 29 and 30 in collaboration with the Annual Southern Conference on Gerontology. The scientific papers to be presented cover the fields of biology, social sciences and clinical medicine. Physicians interested in geriatrics will have an exceptional opportunity to hear distinguished speakers on subjects pertaining to this specialty.

Late in October a questionnaire was mailed by the Committee on Medical Postgraduate Course of the Florida Medical Association to every licensed doctor of medicine in Florida on the subject of graduate medical education, short courses and seminars. Every physician who has not yet returned his questionnaire is urged to do so promptly. The replies will be analyzed and the results published in The Journal early in 1955.

Dr. Russell B. Carson, of Fort Lauderdale, a past president, and Dr. A. Fred Turner Jr., of Orlando, a member of the executive committee of the Southeastern Section of the American Urological Association, attended the annual meeting of the South Central Section of that association, held in Colorado Springs, Colo., October 18-20.

Dr. Paul L. Summers of Miami was presented a citation of merit for his work on behalf of the American Cancer Society, Florida division, during the past year.

Dr. Charles A. Robinson of Delray Beach has returned to his practice after 10 days of postgraduate work in surgery at the Lahey Clinic, Boston.

Dr. Wilbur C. Sumner of Jacksonville spoke on the work of the Cancer Clinic at a joint meeting of the Jacksonville Beach Woman's Club and The Beaches Chapter, American War Mothers, in August.

Dr. Mason Trupp of Tampa spoke on "Nursing Care of Neurosurgical Patients," at a meeting of the Licensed Practical Nurses, Division 13, on October 8.

Dr. James R. Nieder of Delray Beach has returned to his practice after studying with Dr. H. Arruga of Barcelona, Spain. Dr. Arruga is an internationally known eye surgeon.

Dr. Fred F. Porter of Daytona Beach entered medical service with the U. S. Air Force with the rank of first lieutenant, on October 11.

Dr. Nathaniel Jones of Jacksonville has been elected lieutenant governor of Division III, Florida District of Kiwanis International.

Dr. Robert C. Welsh of Miami has returned to his practice after having spent two months observing eye surgery in New Orleans, Atlanta and Philadelphia.

Dr. Ashbel C. Williams of Jacksonville attended several clinics at the Lahey Clinic in September.

Dr. James J. Griffitts of Miami attended the Fifth International Congress of Blood Transfusion, September 13-19, in Paris, France. He presented a paper on "Post Transfusion Reactions with Emphasis on the Common Pyrogenic and Allergic Reaction."

Drs. Joseph J. Lowenthal and J. Q. U. Thompson of Jacksonville have been named advisors to the Jacksonville Area Vocational Rehabilitation Office.

Dr. George W. Robertson III of Miami has returned to his practice following a three months' teaching fellowship at Tulane University of Louisiana School of Medicine in New Orleans.

Dr. A. Judson Graves of Jacksonville took a two week postgraduate course in radiology at the University of Pennsylvania Medical School in September.

Dr. J. Maxie Dell Jr. of Gainesville was elected second vice president of the American Roentgen Ray Society at its annual meeting in Washington, D. C., on September 20.

Dr. Clarence M. Sharp of Jacksonville presided at the meetings of the Southern Tuberculosis Conference in Atlanta in September. He gave a paper on "The Challenge of Early Diagnosis."

Dr. Sharp spoke on the problem of undiscovered tuberculosis at the opening session of the Florida Public Health Association meeting in Miami Beach on October 21.

Dr. Joseph H. Lucinian of Miami attended the meeting of the American Roentgen Ray Society in Washington, D. C., in September.

Dr. Robert C. Lonergan of St. Petersburg attended the meeting of the International Society of Orthopedic and Traumatic Surgery at Berne, Switzerland, September 1. Dr. Lonergan was inducted as a member of the organization.

The North Florida Radiological Society was recently organized with a membership of all of the practicing radiologists in Jacksonville, and other radiologists from North Florida and South Georgia. The Society will hold X-ray discussion meetings four times a year. The September 30 meeting was held at the home of Dr. A. Judson Graves. Dr. Thomas H. Lipscomb is president of the organization, and Dr. Ivan Isaacs is the secretary.

Dr. Bernard L. N. Morgan of Jacksonville attended the meeting of the Association of Plastic Surgeons in Hollywood, October 25-29.

Dr. Morgan spoke at the meeting of the South Georgia Medical Society on November 9 in Valdosta, Ga. His subject was "Problems in Reconstructive Surgery."

Dr. Millard B. White of Sarasota was a guest speaker at the meeting of the Lower West Coast Blood Bank on October 18 in that city.

Dr. Donald H. Gahagen, Fort Lauderdale, is the new president of the American Cancer Society, Florida Division. Other officers named at the recent meeting in Orlando are Dr. Paul J. Coughlin, Tallahaseee, first vice president, and Dr. Joseph J. Zavertnik, Miami, third vice president.

Dr. Clyde F. B. Smith of Miami Beach spoke on "Medical Aspects of Atomic Warfare," at a meeting of the North Shore Lions Club on October 18.

Dr. James V. Freeman of Clearwater spoke at the October meeting of the Tampa Society of X-ray Technicians. His subject was radium.

Dr. Lewis T. Corum of Tampa was chairman of a forum planning committee for a series of open discussions presented by the Guidance Center of Hillsborough County. Dr. Samuel G. Hibbs, also of Tampa, was a member of the committee.

Dr. Walter C. Payne Sr. of Pensacola was elected president of the Gulf Coast Clinical Society at the Fourteenth Annual Convention, and Dr. Barkley Beidleman, also of Pensacola, was elected secretary-treasurer.

Dr. C. Ashley Bird of Jacksonville has returned to his practice after attending the meetings of the Congress of Neurological Surgeons in New York, November 3-6.

Dr. Ashbel C. Williams was moderator and Drs. Joseph A. J. Farrington, Milton C. Maloney, and C. Burling Roesch were members of a panel which discussed cancer and the progress being made in the fight against the disease at the Pythian Center in Jacksonville on October 25.

Drs. Charles McD. Harris Jr. of West Palm Beach, George H. McSwain of Daytona Beach, and Walter A. Derrick of Orlando were among the speakers at the annual meeting of the Florida Division, American Cancer Society, held in Orlando, October 8-10.

Dr. Edgar A. P. Kellerman of West Palm Beach spoke on community health needs at the weekly luncheon meeting of the Soroptimist Club of that city on October 6.

Dr. Leon H. Manheimer of Miami Beach gave a brief talk on cancer at a meeting of the 52 Association of Greater Miami on October 14.

Dr. Ashbel C. Williams of Jacksonville has been named director of the American Cancer Society from Region 3. The election took place at the annual meeting of the society in New York recently.

Dr. Francis A. Reed of Miami Beach spoke on "Heart Disease" at a meeting of the Bal Harbour Rotary Club on October 7.

Dr. Ben J. Sheppard of Coral Gables spoke on polio at the meeting of Holy Family School Parents' Club on October 12.

Dr. Carol C. Webb of Pensacola was honored on October 8 when the library at the Medical Center Clinic in that city was dedicated to him.

Dr. Bernard D. Ross of Miami spoke at a meeting of the Miami Multiple Sclerosis Association on October 10. Dr. Ross is a member of the association's medical advisory board.

Dr. Willett E. Wentzel of Bradenton spoke on "Hospital Ethics" at a meeting of the Memorial Hospital Auxiliary in October.

Dr. Wilson T. Sowder of Jacksonville was named Florida delegate to the American Public Health Association at the meeting of the Florida Public Health Association held in Miami Beach in October.

Dr. Paul N. Unger of Miami Beach spoke on heart disease at a meeting of a Miami Beach chapter of the Disabled American Veterans in October.

Dr. Irwin S. Leinbach of St. Petersburg spoke at an assembly of Junior College students on October 6.

Dr. Jacob Neber of Miami has returned to his practice after participating in the Fifth International Congress of Hematology at The Sorbonne, Paris, France, September 6-13.

At a recent meeting of the Florida Public Health Association in Miami Beach, Dr. Joseph M. Bistowish Jr. of Tallahassee was elected first vice president. Dr. George A. Dame of Jacksonville was re-elected president of the Florida Academy of Preventive Medicine. Dr. Turner E. Cato of Miami was chosen vice president of this organization, and Dr. Lorenzo L. Parks of Jacksonville, secretary-treasurer.

Dr. Carlos P. Lamar of Miami was a guest speaker at the First Annual Meeting of the Cuban Endocrine Society in Matanzos, Cuba, on October 16. He spoke on "A New Interpretation of the Roles of Sugars, Proteins and Fats in the Physiopathology and in the Control of Diabetes Mellitus."

Dr. Lamar was a guest speaker at the Geriatrics Symposium of the American Geriatrics Association at the Hotel Roosevelt, New York, November 12-13. His subject was "The Use of Cortisone in the Palliative Treatment of Advanced Carcinoma."

Dr. F. Gordon King of Jacksonville took a postgraduate course in "Advances in Surgery" at the University of Pennsylvania School of Medicine in October.

The new edition of the American Medical Directory is now in galley form, and it is expected that the book will be ready for delivery about the middle of 1955, according to Frank V. Cargill, Director of Records and Circulation for the A.M.A. The previous edition was published in 1950.

A directory information card has been mailed to every physician in the United States, its dependencies, and Canada, requesting information to be used in compiling the new Directory. Physicians receiving an information card should fill it out and return it promptly regardless of whether any change has occurred in any of the points on which information is requested. There is no charge for publishing the data, nor are physicians obligated in any way.

Dr. Lewis T. Corum of Tampa was installed as president of the Florida Pediatric Society at the October meeting of the Society in St. Petersburg. Dr. Wesley S. Nock of Coral Gables was elected president-elect, and Dr. Joel V. McCall Jr. of Daytona Beach was elected secretary-treasurer. Drs. C. Jennings Derrick of West Palm Beach and J. K. David Jr. of Jacksonville were named to the executive committee.

Dr. Lawrence E. Geeslin of Jacksonville took part in a television panel discussion on Community Chest-United Fund Benefits in September.

Dr. Floyd K. Hurt of Jacksonville spoke at the opening fall meeting of the Woman's Auxiliary to the Duval County Medical Society. He discussed various phases of medical costs in the United States.

The eighteenth annual meeting of the New Orleans Graduate Medical Assembly will be held March 7-10, 1955. Eighteen outstanding guest speakers will participate and their presentations will be of interest to both specialists and general practitioners. The Assembly has planned another interesting postclinical tour to follow the meeting.

Details of the meeting and the tour are available at the office of the Assembly, Room 103, 1430 Tulane Ave., New Orleans 12.

Dr. Lillian C. Mark of Jacksonville has been named by the Jacksonville Business and Professional Woman's Club to receive a merit award for achievement in the field of medicine.

The Texas Medical Center at the University of Texas in Houston, which has been tracing the interest in cancer in medical societies, has informed the Association that Florida's Cancer Control Committee was one of the first to be established. The Committee was established by action of the House of Delegates on May 2, 1933.

Dr. Samuel M. Wells of Jacksonville spoke at the September meeting of the Duval County Muscular Dystrophy Association. His subject was the research now being done in this field.

Dr. Sullivan G. Bedell of Jacksonville took part in a panel discussion on the work of the Governor's Committee on Training and Research in Mental Health at the September meeting of the Northeast Florida Association for Mental Health.

The First Annual Meeting of the Texas Geriatrics Society will be held in January 1955 at the Southwestern Medical School Center on a Saturday and Sunday. All business of the society and the nomination of officers will be held on Saturday, and the scientific program and election of officers will be held on Sunday.

A program is being arranged which will cover the subjects of Geriatrics, Gerontology and the Welfare of the Aged, with two speakers from out-of-state medical schools and four from Texas medical schools.

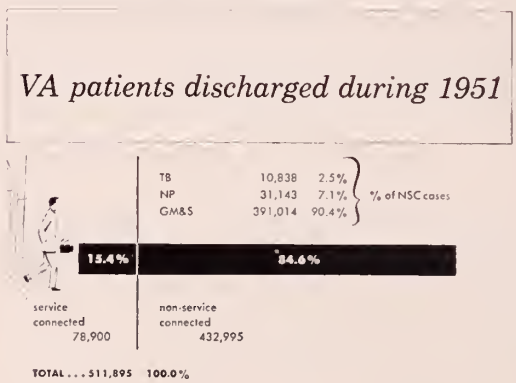
Further information may be obtained from the president, Henry H. Niehuss, M.D., Longview, Tex.

Dr. Rothwell C. Polk of Jacksonville spoke on "Cancer of the Breast" before the Women's Missionary Union of the Hogan Baptist Church in that city on November 2.

A postgraduate course on Venereal Disease for Practicing Physicians is to be offered Jan. 31-Feb. 4, 1955, by the Division of Graduate Medicine of Tulane University School of Medicine with the cooperation of the United States Public Health Service. All aspects of the venereal disease problem will be covered by nationally known authorities in this field. The course is approved by the American Academy of General Practice and no tuition fee will be charged. Further information can be obtained from the Director of Graduate Medicine, 1430 Tulane Ave., New Orleans 12.

Dr. John G. DuPuis of Miami has just completed a book entitled, "Early Medical History of Dade County." It is expected that the book will be off the press about December 15. Dr. DuPuis has been doing research and writing on the book for three years.

In Viewing the VA Medical Program . . .



Of 511,895 patients discharged from VA hospitals in 1951, only 15.4% were treated for illnesses or injuries incurred as a result of military service. Physicians believe it is unsound to continue authorization of "free" lifetime medical care for those who suffer no mishap while in uniform, while other citizens with no military background must pay their own way.

Ten full scholarships for Florida professional people to attend the Yale University School of Alcohol Studies are offered by the new Florida State Alcoholic Rehabilitation Program.

Ernest A. Shepherd, administrator of the program, has announced that the scholarships will cover tuition, room and board for the summer session which ordinarily runs from July 5 through July 29. The scholarships are open to doctors of medicine, public health officials, social workers, educators, clergymen, and other persons interested in alcoholism. Final approval for all applications is made by the Alcoholic Rehabilitation Program Advisory Council and the Yale Committee on Admissions.

The Yale School of Alcohol Studies offers an intensive orientation in the modern research on the problems of alcohol. The Yale School session consists of lectures by authorities in the field of alcoholism and special interest seminars. The enrollment is limited to 150 students selected from throughout the nation.

WANTED — FOR SALE

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

INTERNIST-ALLERGIST: Desires association or group. University training. Age 45. Florida license. Priority IV. Available immediately. Consider any opening. Write 69-135, P.O. Box 1018, Jacksonville, Fla.

WANTED: General Practitioner for group practice in southeast coast area. No surgery, obstetrics required. Write 69-138, P.O. Box 1018, Jacksonville, Fla.

RADIOLOGIST: (Diagnosis, therapy). American graduate. Florida license. Available July 1955. Board-eligible. Trained leading Southern University Center. Family. No military commitments. Interested hospital or association. Write 69-139, P.O. Box 1018, Jacksonville, Fla.

ASSISTANT: Or Associate. Available immediately. Age 36, married. One year ob-gyn, one year pathology, four years general surgery. Florida license. Write 69-140, P.O. Box 1018, Jacksonville, Fla.

WILL RELIEVE: General practitioner, Miami, Dec. 27-Jan. 14. Medical College of Virginia graduate, 1951, one year rotating internship, one year g.p., now in surgical residency. Florida license. Reply Box 38, 1601 Perdido St., New Orleans, La.

RETIRING: Because of ill health. Giving practice and office equipment to Doctor buying my home. Fishing resort. Write 69-141, P.O. Box 1018, Jacksonville, Fla.

SURGEON: Young, Board eligible in December, married, Category IV, desires association with established surgeon, group or hospital requiring general surgeon. Florida licensed. Available January. Write 69-142, P.O. Box 1018, Jacksonville, Fla.

COMPONENT SOCIETY NOTES

Broward

The Broward County Medical Association has paid 100 per cent of its state dues for 1954.

Dade

The regular monthly meeting of the Dade County Medical Association was held on October 5 at the Miami Woman's Club.

At the regular monthly meeting on November 2, Dr. Robert B. Lawson, Professor of Pediatrics, University of Miami School of Medicine, spoke on "Treatment of Tetanus."

Duval

The regular monthly meeting of the Duval County Medical Society was held on October 5 at which time Dr. Mason Romaine III spoke on "Diuresis in Conjunctive Heart Failure."

At the regular monthly meeting held on November 2, Dr. Nelson A. Murray spoke on "Protein Bound Iodine, A Newer Aid in Medical Diagnosis."

Lake

The new officers of the Lake County Medical Society are: Dr. Louis R. Bowen, Eustis, president; Dr. Raymond A. Debo, Eustis, vice president; and Dr. J. Basil Hall, Tavares, secretary-treasurer.

Lee-Charlotte-Collier-Hendry

At the regular meeting of the Lee-Charlotte-Collier-Hendry County Medical Society held in Punta Gorda on October 18, Dr. Michael A. DiCosola of Sarasota was the guest speaker.

Leon-Gadsden-Liberty-Wakulla-Jefferson

The Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society met on October 21 at the Sawano Club in Quincy. Guest speakers for the evening were Dr. George T. Harrell Jr., Dean of the College of Medicine of the University of Florida, and Dr. P. A. Foote, Dean of the College of Pharmacy. Dr. Harrell spoke on the physical and administrative aspects of the college, and Dr. Foote spoke on the objectives in the progress of the bureau of public relationship.

Announcing The Eighteenth Annual Meeting of

THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

Conference Headquarters - Municipal Auditorium - March 7-10, 1955

GUEST SPEAKERS

Donald H. Stubbs, M.D., Washington, D. C.
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Marcus R. Caro, M.D., Chicago, Ill.
Dermatology
Joseph B. Kirsner, M.D., Chicago, Ill.
Gastroenterology
Willis E. Brown, M.D., Little Rock, Ark.
Gynecology
Tinsley R. Harrison, M.D., Birmingham, Ala.
Internal Medicine
Donald W. Seldin, M.D., Dallas, Tex.
Internal Medicine
William A. Sodeman, M.D., Columbia, Mo.
Internal Medicine
Leonard T. Furlow, M.D., St. Louis, Mo.
Neurosurgery
Thaddeus L. Montgomery, M.D., Philadelphia, Pa.
Obstetrics
F. Bruce Fralick, M.D., Ann Arbor, Mich.
Ophthalmology
George J. Garceau, M.D., Indianapolis, Ind.
Orthopedic Surgery
Jerome A. Hilger, M.D., St. Paul, Minn.
Otolaryngology
William Boyd, M.D., Toronto, Canada
Pathology
Louis K. Diamond, M.D., Boston, Mass.
Pediatrics
H. Dabney Kerr, M.D., Iowa City, Iowa
Radiology
B. Marden Black, M.D., Rochester, Minn.
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Charles B. Puestow, M.D., Chicago, Ill.
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LECTURES, SYMPOSIA, CLINICOPATHOLOGIC CONFERENCES, ROUND-TABLE LUNCHEONS, MEDICAL MOTION PICTURES, SCIENTIFIC EXHIBITS AND TECHNICAL EXHIBITS.
(All-inclusive registration fee — $20.00)

THE POSTCLINICAL TOUR TO EUROPE BY PLANE AND SHIP
Departure from New York, March 12

For information concerning the Assembly meeting and the tour write
Secretary, Room 103, 1430 Tulane Avenue, New Orleans 12, La.

Manatee

The Manatee County Medical Society has paid 100 per cent of its state dues for 1954.

Marion

The regular monthly meeting of the Marion County Medical Society was held on October 19 at the Elks Club in Ocala. Dr. Raymond Arp of Atlanta, Ga., was the guest speaker, and his subject was "Allergic Principles in General Practice."

Pinellas

Officers of the Pinellas County Medical Society for 1955 are Drs. Clyde O. Anderson, St. Petersburg, president; Daniel F. H. Murphey, St. Petersburg, president-elect; Richard Reeser Jr., St. Petersburg, first vice president; Claude G. Hooten Jr., Clearwater, second vice president; and Whitman C. McConnell, St. Petersburg, secretary-treasurer.

The Society opened its fiscal year with a meeting in St. Petersburg on November 1. Speaker was Senator Spessard Holland, and members of the Hillsborough, Manatee and Sarasota County Medical Societies were invited to attend the meeting.

Polk

Dr. James L. Bradley of Fort Myers spoke on "Problems of the Veterans Administration" at the fall dinner of the Polk County Medical Society held on October 13 at the Lakeland Yacht and Country Club.

OBITUARIES

Bascom Headen Palmer

Dr. Bascom Headen Palmer of Miami died at his home on Sept. 2, 1954, after a long illness. He was 64 years of age.

A native Floridian, Dr. Palmer was born in Lake City in 1889. From a family known in the annals of the state chiefly in legal circles, he was the son of the late Judge B. H. Palmer. In 1914, he was graduated from the Tulane University of Louisiana School of Medicine as president of his class. Shortly after he won the degree of Doctor of Medicine, he entered military service. He served during World War I as a captain in the United States Air Force.

Dr. Palmer received his license to practice medicine in Florida in 1915. In the early twenties he practiced in Tampa. After completion of graduate work at the University of Pennsylvania, he located in Miami in 1923, opening practice there in the fields of ophthalmology and otolaryngology. In 1928 he was certified by the American Board of Ophthalmology and thereafter confined his practice to ophthalmology.

Locally, Dr. Palmer was a leader professionally and also in many community projects. When the University of Miami was first established in 1926, he became a trustee and in recent years was active in helping to establish the medical school there. He was also a trustee of the Dade County Blood Bank and adviser to the Dade County Health Department. A particular interest was the Lighthouse for the Blind, which he served for many years as a director and for which he donated the site. Another was the Florida Council for the Blind, of which he was a past president.

Dr. Palmer was a former national consultant of the National Society for the Prevention of Blindness. Recently he received a citation from President Eisenhower's committee for the physically handicapped. He won recognition from the Miami Chamber of Commerce for similar service and also was the recipient of service plaques from the Dade County Blood Bank and the Miami Rotary Club, of which he was a member.

A member of the Dade County Medical Association, Dr. Palmer had been a member of the Florida Medical Association for 29 years. He also held membership in the American Medical Association, the Southern Medical Association, the American Academy of Ophthalmology and Otolaryngology and the Florida Society of Ophthalmology and Otolaryngology, of which he was a past president. In addition, he was a fellow of the American College of Surgeons.

Surviving are the widow, Mrs. Helen E. Palmer; two daughters, Mrs. Robert Kurtz and Miss Nancy Palmer; and two grandchildren, all of Miami; also, one brother, G. O. Palmer, of Miami Beach.

Amebiasis[1] a "Poorly Reported" Disease

Until serious complications arise, amebiasis may pass unrecognized and patients receive only symptomatic treatment.

Although amebiasis is a disease with serious morbidity and mortality, statistics on its incidence[1] are incomplete because its manifestations are not commonly recognized and consequently not reported.

"*Vague symptoms[2] referable to the gastrointestinal tract, such as indigestion or indefinite abdominal pains, with or without abnormally formed stools, may result from intestinal amebiasis. Not infrequently in cases in which such symptoms are ascribed to psychoneurosis after extensive x-ray studies have been carried out, complete relief is obtained with antiamebic therapy.*"

To prevent possible development of an incapacitating or even fatal illness and to eliminate a reservoir of infection in the community, diagnosing and treating[3] even seemingly healthy "carriers" and those having mild symptoms of amebiasis is advised.

Early diagnosis[1] is important because infection can be rapidly and completely cleared, with the proper choice of drugs and due consideration for the principles of therapy. For treatment of the bowel phase these authors find Diodoquin "most satisfactory."

For chronic amebic infections, Goodwin[4] finds Diodoquin to be one of the best drugs at present available.

Diodoquin, which does not inconvenience the patient or interfere with his normal activities, may be used in the treatment of acute or latent forms of amebiasis. If extraintestinal lesions require the use of emetine, Diodoquin may be administered concurrently. It is a well tolerated and relatively nontoxic orally administered amebacide, containing 63.9 per cent of iodine.

Diodoquin (diiodohydroxyquinoline), available in 10-grain (650 mg.) tablets, reduces the course of treatment to twenty days (three tablets daily). Treatment may be repeated or prolonged without serious toxic effect. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.



Endamoeba histolytica (trophozoite).

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1. Hamilton, H. E., and Zavala, D. C.: Amebiasis in Iowa: Diagnosis and Treatment, J. Iowa M. Soc. *42*:1 (Jan.) 1952.

2. Goldman, M. J.: Less Commonly Recognized Clinical Features of Amebiasis, California Med. *76*:266 (April) 1952.

3. Weingarten, M., and Herzig, W. F.: The Clinical Manifestations of Chronic Amebiasis, Rev. Gastroenterol. *20*:667 (Sept.) 1953.

4. Goodwin, L. G.: Review Article: The Chemotherapy of Tropical Disease: Part 1. Protozoal Infections, J. Pharm. & Pharmacol. *4*:153 (March) 1952.

WOMAN'S AUXILIARY

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Planning Projects, Past, Present and Future

Each year as we approach the Christmas Season and the New Year, it seems a good time to stop and take stock of what we have done, what we are doing and what we plan to do through the rest of this Association and Auxiliary year and in years to come. So this December article will be devoted to these reflections.

The year's accomplishments that are finished as of now include the American Medical Association Clinical Session in Miami, in which the Auxiliary took its share of planning and action; the four District Workshop Meetings held in conjunction with the Association District Meetings at which about 275 women in all were present; the district meeting of Future Nurses' Clubs in District C under the chairmanship of our Nurse Recruitment Chairman, Mrs. Augustine S. Weekley, at which over 100 students were present; the mid-year board meeting in St. Petersburg under the chairmanship of our Hospitality Chairman, Mrs. George H. Anderson; the beginning of the distribution of our pamphlets on Good Health Insurance and our distribution for the Association of two booklets, "FMA, Facts, Methods and Activities," and "A Positive Public Relations Program."

At the present, work on the redecorating of the Duval Brewster School of Nursing sitting rooms is going forward, and books are being bought for this library to bring it up to standard as a Nursing School Library. The Health Fair for the Public in Miami is on with the A.M.A., F.M.A. and D.C.M.A. auxiliaries collaborating in the first showing of a nurse recruitment exhibit. The pamphlets on Good Health Insurance are being distributed through this fair; collections of sums for the American Medical Education Foundation are being made in many auxiliaries, and plans are being made for the Christmas gifts to be sent to our Florida State Hospitals and Farm Colony. Materials of occupational therapy for these state institutions are being gathered.

All of our component auxiliaries have started their meetings and are well underway with the national, state and local programs and projects. Three issues of the *Medaux* have been finished; the last of these is in the mail at this time. Loans have been made to component auxiliaries to allow them to send a student to nursing school and $200 has been added to this fund from our budget this year.

Plans have been completed for future participation of component auxiliaries in future projects to be done before the end of the auxiliary year. The nurse recruitment exhibit now on display at the Health Fair in Dade County will be kept in Florida and will have two further showings: the Florida State Fair in Tampa, February 5-19, and the Florida Medical Association Convention and Annual Meeting in St. Petersburg, April 3-6.

Today's Health Exhibits will also be shown at these two meetings, and a special drive to obtain subscriptions from every doctor in the state will

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Pictured at the Midyear Board Meeting and Conference of County Presidents and Presidents-elect held in St. Petersburg, September 21-22, are F.M.A. President Duncan T. McEwan, Orlando; Auxiliary President Mrs. Richard F. Stover, Miami; Mrs. McEwan; and Dr. Charles R. Sias, Orlando, a member of the F.M.A. Committee on Advisory to the Woman's Auxiliary.

be made from December through April. A spot check of the use of *Today's Health* by patients in the doctor's office waiting room in Florida shows that five patients per day (23 days per month) use this magazine and thereby obtain some good health information while waiting to see their doctors. This sums up to 115 patients per month who obtain correct and factual information while waiting for their doctors. The problem here is that so very few of the doctors in Florida have copies of *Today's Health* available in their waiting rooms, and the Auxiliary hopes by April to have copies in every doctor's office waiting room throughout the state.

Plans are in the making for a fine convention in St. Petersburg, April 3-6, and although these plans are as yet tentative, the annual Auxiliary luncheon will be set up for both the doctors and their wives this year with a nationally known speaker, Governor Georne N. Craig, of Indiana.

This is but a partial report of what has been done, is being done and is planned for the future. Of one particular point we can be sure, and that is that the fine cooperation of the F.M.A. officers, advisory committee, office staff and personnel will be continued. The Auxiliary appreciates this cooperation and realizes what it means in terms of time, advice and interest on the part of the Florida Medical Association. We can also be sure on another particular point, and that is that the Florida Auxiliary with all its component parts will continue to serve the Florida Medical Association, the county auxiliaries and act as liaison between them and the American Medical Association Auxiliary.

After having put down all of the above projects, the one and only project left is, to me, the most important. Year by year, day by day and hour by hour your Auxiliary continues to work for patient understanding and true friendship between doctors' families throughout Florida, and we believe that we work at this with a good deal of success. This, I believe, is our real worth.

Merry Christmas and a New Year filled with friendship, understanding, tolerance, peace and contentment.

Mrs. Richard F. Stover, President

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BOOKS RECEIVED

A Methodological, Psychiatric and Statistical Study of a Large Swedish Rural Population. By Tage Larsson and Torsten Sjögren. Pp. 250. Copenhagen. Ejnar Munksgaard, 1954.

This study comes from the Department of Psychiatry, Karolinska Institutet Medical School, University of Stockholm (Head: Professor Torsten Sjögren, M.D.). Its aim is to make a statistical and genetic analysis of psychoses and low grade oligophrenia over a relatively long period and in a geographically limited area, the period method of investigation being used. The study was planned and carried out in such a way that it has been possible to make, besides a research on the prevalence of psychoses and low grade oligophrenia in the general population, also an analysis of the frequency and morbidity risks of mental disorders among the parents and sibs of psychotic and oligophrenic probands.

Sweden offers particularly favorable possibilities for population studies and family investigations in the field of psychiatry. For a very long time careful statistics of the population have been kept in that country, and cases of mental disease and mental deficiency must, according to the law, be recorded in the parish registers. The population is relatively homogeneous, and the social and economic class differences are comparatively small. The material used in this study covers 45 years of registration for a rural Swedish area with about 25,000 inhabitants, and comprises 1,312 registered cases of psychosis, severe psychopathy, low grade oligophrenia and suicide. The results of the investigation are being published in two parts, of which this book is the first part. It deals with methods and basic material, analysis of the material with reference to completeness, homogeneity and representative character, the results concerning age of onset of the disease, hospitalization and mortality, and concerning the morbidity risks in the general population. Later, the second part will deal with the results of the family investigation relating to the morbidity risks for parents and sibs of 1,028 psychotic, psychopathic and oligophrenic probands, and the results of the clinical and genetic analysis of the material (T. Sjögren and T. Larsson: A Genetic, Clinical and Statistical Study of Psychoses and Oligophrenia in a Large Swedish Rural Population).



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Illustrated Review of Fracture Treatment. By Frederick Lee Liebolt, A.B., M.D., Sc.D., LL.D. Pp. 229. Price, $4.00. Los Altos, Calif., Lange Medical Publications, 1954.

This review is intended to illustrate and to discuss, briefly and systematically, the principal features concerning the diagnosis and treatment of fractures. It has been written for the medical student, the house officer, and the general practitioner. There has been no attempt to make the book comprehensive or complete in all details, nor has it been written to promote discussion. It is to serve instead as a supplement to the standard texts in the field. The first three of the 17 chapters deal with Anatomy and Physiology, Clinical Examination of Fractures, and Principles of Treatment of Fractures; the remaining chapters with fractures of the head and face, vertebral column, thorax, shoulder, arm, elbow, forearm, wrist, hand, pelvis, hip and thigh, knee, leg, ankle, and foot, in the order named.

The author is Attending Surgeon in Charge of Orthopedics, the New York Hospital; Attending Orthopedic Surgeon, Hospital for Special Surgery; and Associate Professor of Clinical Surgery (Orthopedics), Cornell University Medical College.

Planning Florida's Health Leadership: A Summary. By Russell S. Poor, Ph.D. Pp. 93. Price, $1.50. Gainesville, Fla., University of Florida Press, 1954.

This Summary is the first volume of a series of volumes, edited by Louis J. Maloof, under the general title Planning Florida's Health Leadership. It presents an over-all picture of the pioneer project conducted at the University of Florida by the Medical Center Study. After the state legislature in 1949 authorized the establishment of schools of medicine and nursing at the University of Florida, this Study was inaugurated, and its work made possible by a grant from the Commonwealth Fund of New York.

In bestowing the grant during the presidency of the late Dr. J. Hillis Miller, the Commonwealth Fund said: "The University of Florida is thinking like a university. Charged by the state legislature to develop schools of medicine and nursing in a medical center, it has taken steps to fit the center not merely to the university matrix in which it will operate but to the state whose health needs it must serve. It has begun a broad-gauge study of the state and of the resources already present in the university which can and should be woven into the pattern of medical education. . . . The time is short and the task ambitious, but the effort to think out what a medical school ought to be and do before a staff is hired and building plans are fixed is all but of unheard of in the recent history of American medical education."

Aware of the ever greater emphasis medicine is placing upon the total health of man — physical, psychological, and social — the Study has planned a program designed to produce the best possible training for the Florida medical student. Subsequent volumes will detail the processes which will enable The J. Hillis Miller Health Center to utilize existing resources and to make the greatest contribution to the University, the community, and the State of Florida.

Dr. Russell S. Poor, author of volume 1 of the Medical Center Study Series, is Provost of The J. Hillis Miller Health Center. A distinguished educator and scientist, he was chairman of the University Relations Division of the Oak Ridge Institute of Nuclear Studies and research associate of the National Science Foundation before coming to the University of Florida to direct the Medical Center Study.

The Physician and His Practice. Edited by Joseph Garland, M.D. Pp. 270. Price, $5.00. Boston, Little, Brown and Company, 1954.

This book is a collection of essays by 18 authorities in their respective fields, each making his original contribution to the understanding if not always to the immediate solution of the special problem on which he writes. While it is planned primarily as a source book of information for the young doctor, it is also a book that practitioners of longer standing will find of value in reviewing their methods of practice, their material equipment, and the resources of the communities in which they live and work.

Proper emphasis is placed on the character and personality of the physician and the standards expected of him — and of his wife — in relation to the two important circles in which they move: the intimate family circle and the larger community circle. Here defined are the fields that medicine now encompasses, with discussions of the various types of activities they offer, the necessity of hospital affiliations, the place of organization and organizations in the profession, and the physician's need for continued study — for gaining knowledge and for imparting it. Certain chapters are devoted to the business considerations of medical practice, in an effort to help the physician appreciate the importance of conducting the business of his profession in a clear and orderly fashion, acceptable to himself, to his patients, and to the tax collector — a major contribution to good public relations in medicine.

The editor, Dr. Joseph Garland, is the editor of The New England Journal of Medicine, and the list of distinguished contributors contains important names in medicine. Their advice on many matters should be most welcome and helpful to many physicians.



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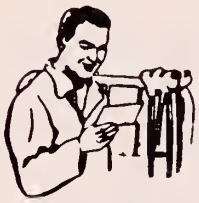
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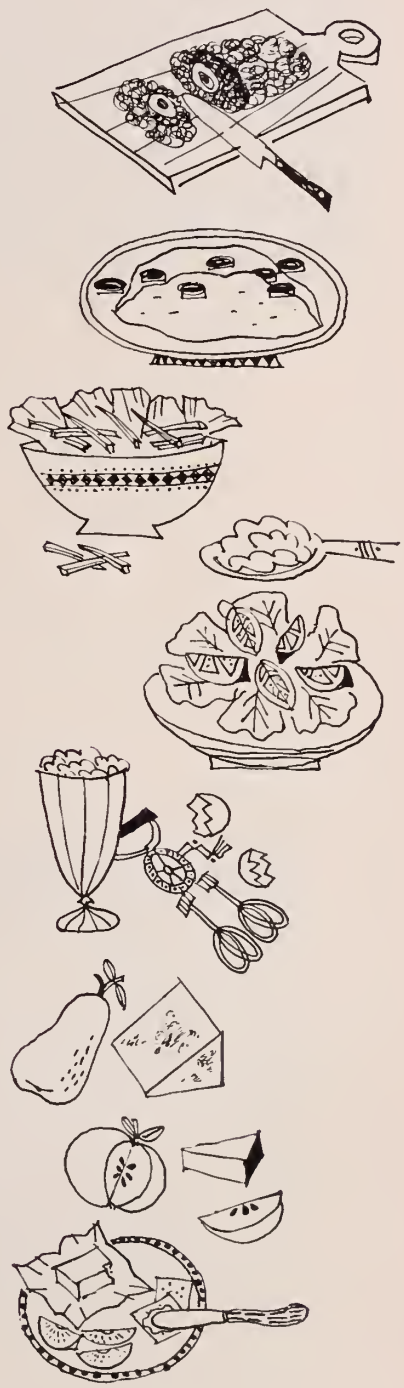
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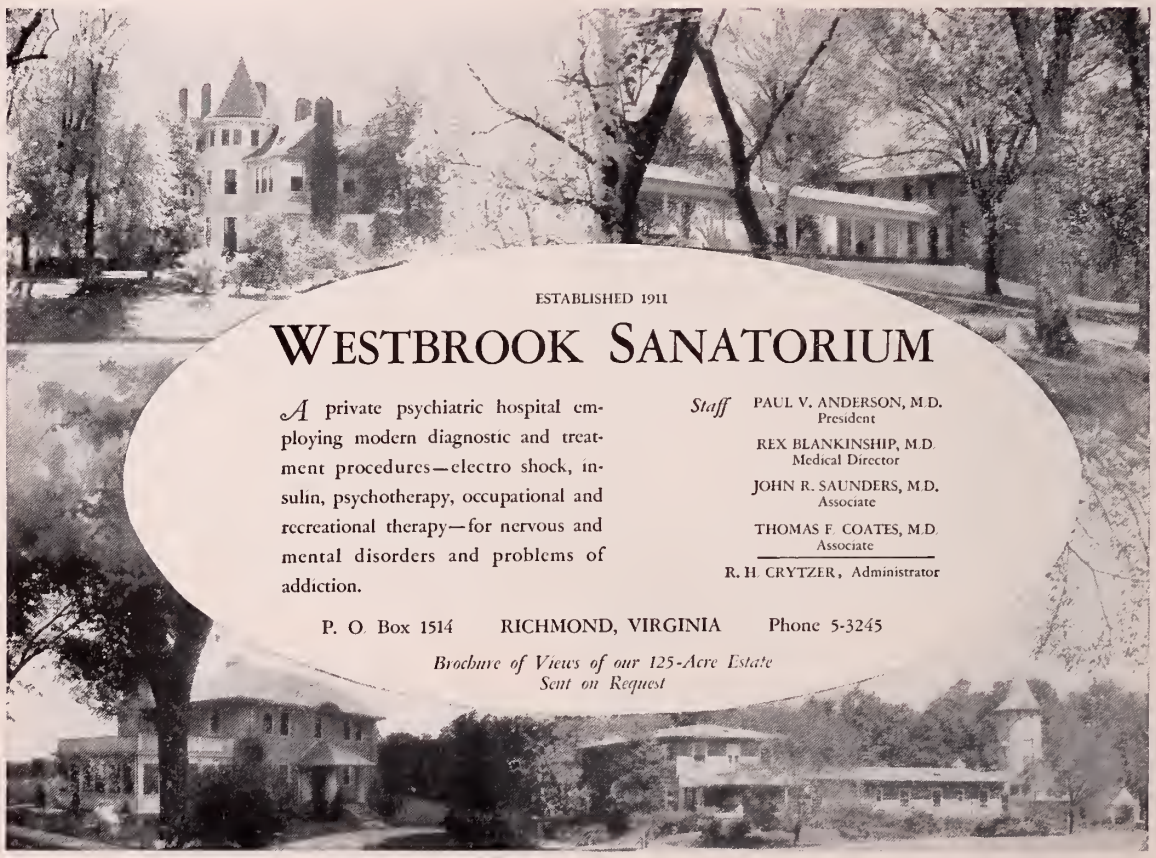
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
rida Medical Association	Duncan T. McEwan, Orlando	Samuel M. Day, Jacksonville	St. Petersburg, Apr. 3-6, '55
rida Medical Districts	Francis H. Langley, St. Petersburg	Council Chairman	
-Northwest	William H. Hixon, Pensacola	George S. Palmer, Tallahassee	Pensacola
-Northeast	Henry J. Babers Jr., Gainesville	Thomas C. Kenaston, Cocoa	Gainesville
-Southwest	Clyde O. Anderson, St. Petersburg	James R. Boulware Jr., Lakeland	Lakeland
-Southeast	James R. Sory, West Palm Beach	Russell B. Carson, Ft. Lauderdale	Fort Lauderdale
rida Specialty Societies			
demy of General Practice	Leonard L. Weil, Miami Beach	Leon S. Eisenman, Hialeah	St. Petersburg, Apr. 3, '55
rgy Society	Solomon D. Klotz, Orlando	Edwin P. Preston, Miami	" "
sthesiologists, Soc. of	R. Gaylord Lewis, West Palm Beach	Harry E. Bierley, West Palm Beach	" "
st Phys., Am. Coll., Fla. Chap.	DeWitt C. Daughtry, Miami	Jack Reiss, Coral Gables	" "
m. and Syph., Assn. of	Hollis F. Garrard, Miami	Joseph A. J. Farrington, Jacksonville	" "
lth Officers' Society	Thomas E. Morgan, Jacksonville	Lorenzo L. Parks, Jacksonville	" "
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asic Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, May 14, '55
lood Banks, Association	John T. Stage, Jacksonville	John B. Ross, Jacksonville	St. Petersburg, 1955
lue Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	
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ental Society, State	Robt. Thoburn, D.D.S.,Daytona Bch	J. E. Edwards, D.D.S., Coral Gables	Jacksonville, Apr. 23-25, '55
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ledical Examining Board	Frank D. Gray, Orlando	Homer L. Pearson Jr., Miami	Jacksonville, June 20-25, '55
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urses Association, State	Martha Wolfe, R.N., Coral Gables	Agnes Anderson, R.N., Orlando	
harmaceutical Association, State	Mr. J. L. McDonald, St. Augustine	Mr. R. Q. Richards, Ft. Myers	Clearwater, May '55
ublic Health Association	Mr. J. A. Mulrennan, Jacksonville	Mr. Fred B. Ragland, Jacksonville	
rudeau Society	Lawrence C. Manni, Tallahassee	Simon D. Doff, Jacksonville	Miami, May 12-14, '55
uberculosis & Health Assn.	Judge Ernest E. Mason, Pensacola	Mrs. W. J. Norton, Sarasota	Miami, May 12-14, '55
/oman's Auxiliary	Mrs. Richard F. Stover, Miami	Mrs. S. J. Wilson, Ft. Lauderdale	St. Petersburg, Apr. 3, '55
erican Medical Association	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	Atlantic City, June 6-10, '55
.M.A. Clinical Session	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	Boston, Nov. 29-Dec. 2, '55
thern Medical Association	Alphonse McMahon, St. Louis	Mr. C. P. Loranz, Birmingham	St. Louis, Nov. 8-11, '54
ama Medical Association	J. M. Donald, Birmingham	Douglas L. Cannon, Montgomery	Montgomery, Apr. 21-23, '55
rgia, Medical Assn. of	Peter B. Wright, Augusta	David Henry Poer, Atlanta	Augusta, May 1-4, '55
Hospital Conference	Mr. John W. Gill, Vicksburg, Miss.	Mr. Pat Groner, Pensacola	Atlanta, Apr. 20-22, '55
theastern Allergy Assn.	W. L. Rucks, Memphis, Tenn.	Kath. B. MacInnis, Columbia, S. C.	Orlando, 1955
theastern, Am. Urological Assn.	Sam L. Raines, Memphis, Tenn.	Robert F. Sharp, New Orleans	New Orleans Mar. 20-23, '55
theastern Surgical Congress	J. Duffy Hancock, Louisville, Ky.	B. T. Beasley, Atlanta	Atlanta, Mar. 7-10, '55
f Coast Clinical Society	Walter C. Payne Sr., Pensacola	Barkley Beidleman, Pensacola	Pensacola, Oct. 1955

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SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Total Members
Alachua	Henry H. Graham, Gainesville	Glenn O. Summerlin, Gainesville	2nd Tues.	52
***Bradford, Gilchrist, Union**				
Bay	Lemuel F. Coxe Jr., Panama City	James D. Nixon, Panama City	1st Tues.	26
Brevard	Theodore J. Kaminski, Melbourne	Isabel Roberts, Melbourne	2nd Tues.	28
Broward	Julius F. Boettner, Fort Lauderdale	George T. F. Rahilly, Fort Lauderdale	4th Tues.	116
Columbia	Robert B. Harkness, Lake City	Thomas H. Bates, Lake City	1st Mon.	12
***Baker, Hamilton**				
Dade	Edward W. Cullipher, Miami	Kenneth S. Whitmer, Miami	1st Tues.	680
DeSoto-Hardee-Highland-Glades	Carl J. Larsen, Avon Park	Samuel A. King, Avon Park	2nd Tues.	27
Duval	Karl B. Hanson, Jacksonville	Jackson L. Allgood Jr., Jacksonville	1st Tues.	274
***Clay**				
Escambia	Wilton E. Tugwell, Pensacola	Paul F. Baranco, Pensacola	2nd Tues.	105
***Santa Rosa**				
Franklin-Gulf	Albert L. Ward, Port St. Joe	Warren T. Weathington, Apalachicola	Last Wed.	9
Hillsborough	C. Frank Chunn, Tampa	Julien C. Pate Jr., Tampa	1st Tues.	181
Indian River	William L. Fitts 3rd, Vero Beach	Vernon L. Fromang, Vero Beach	2nd Tues.	10
Jackson-Calhoun	Jabe A. Breland, Marianna	Francis M. Watson, Marianna	Quarterly	17
Lake	Louis R. Bowen, Eustis	J. Basil Hall, Tavares	1st Wed.	29
***Sumter**				
Lee-Charlotte-Collier-Hendry	H. Quillian Jones, Fort Myers	James L. Bradley, Fort Myers	3rd Mon.	37
Leon-Gadsden-Liberty-Wakulla-Jefferson	George H. Massey, Quincy	Odis G. Kendrick Jr., Tallahassee	Quarterly	60
Madison	Wallace E. Winter, Madison	Julian M. DuRant, Madison		5
Manatee	Willett E. Wentzel, Bradenton	Marjorie L. Warner, Bradenton	2nd Tues.	25
Marion	William H. Anderson Jr., Ocala	Bertrand F. Drake, Dunnellon	3rd Tues.	30
***Levy**				
Monroe	Edward Gonzalez, Key West	Herman K. Moore, Key West	2nd Thurs.	12
Nassau	David G. Humphreys, Fernandina	John W. McClane, Fernandina	Last Fri.	11
Orange	Eugene L. Jewett, Orlando	Andrew W. Townes Jr., Orlando	3rd Wed.	180
***Osceola**				
Palm Beach	Thomas E. Daly, West Palm Beach	David A. Newman, Palm Beach	4th Mon.	135
Pasco-Hernando-Citrus	Frank Y. Robson, New Port Richey	W. Wardlaw Jones, Dade City	2nd Thurs.	17
Pinellas	Clyde O. Anderson, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	212
Polk	Theodore C. Keramidas, Winter Haven	James T. Shelden, Lakeland	2nd Wed.	89
Putnam	Lawrence G. Hebel, Palatka	James A. Long Jr., Palatka	2nd Tues.	10
St. Johns	James J. DeVito, St. Augustine	Reuben J. Plant Jr., St. Augustine	3rd Tues.	19
St. Lucie-Okeechobee-Martin	Laurance D. Van Tilborg, Ft. Pierce	Adrian M. Sample, Fort Pierce	3rd Thurs.	22
Sarasota	Henry J. Vomacka, Sarasota	Lloyd J. Duest, Sarasota	2nd Tues.	53
Seminole	J. Clifford Boyce, Sanford	Terry Bird, Sanford	2nd Tues.	20
Suwannee	William P. Blackmon, Mayo	Hiram B. Curry, Jasper	1st Sat.	9
Taylor	George H. Warren, Perry	Walter J. Baker, Foley	Last Fri.	4
***Dixie, Lafayette**				
Volusia	Cleland D. Cochrane, Daytona Beach	Robert L. Miller, Daytona Beach	2nd Tues.	84
***Flagler**				
Walton-Okaloosa	Robert von P. Maxon, Fort Walton	Arthur G. Williams Jr., Valparaiso	3rd Thurs.	20
Washington-Holmes	Ralph H. Segrest, Bonifay	Baylye W. Dalton, Chipley		6
			Total	2,626

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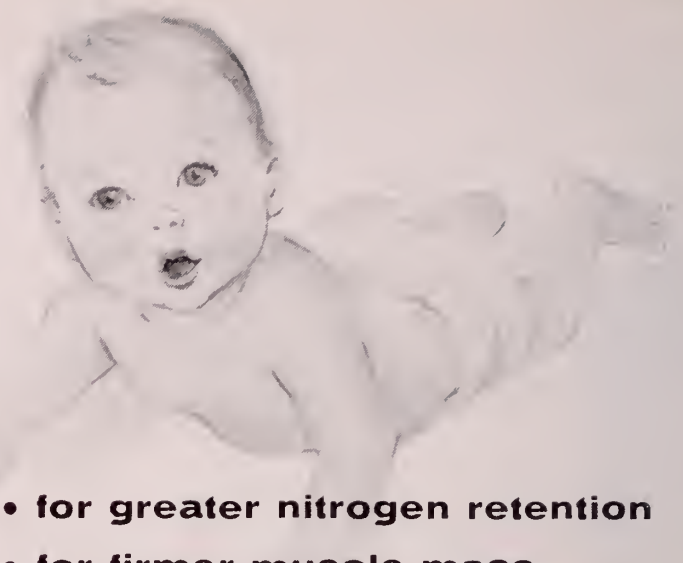


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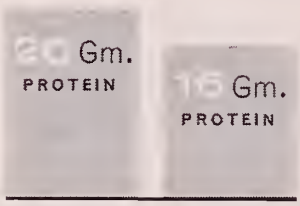


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1. Jeans, P. C., in A.M.A. Handbook of Nutrition, Philadelphia, Blakiston, 1951, pp. 275-298. 2. Stare, F. J., and Davidson, C. S., in The Proteins, American Medical Association, 1945.

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The Journal
OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XLI JANUARY, 1955 No. 7

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St. Petersburg – April 3-6, 1955

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John M. Rumball

Cortisone and Infections
John P. Rowell

Four Decades of Otolaryngology
Mozart A. Lischkoff

Atypical Constriction of Aorta
Robert H. Nickau

Malpractice Insurance Problem
Part II

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Volume XLI JANUARY, 1955 No. 7

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According to criteria such as "physical activity, gastrointestinal structure and function, pathologic disturbances, and chemical balances," it is suggested that an optimal diet for the elderly patient should provide at least 20 per cent of its calories in the form of protein.[3]

For several reasons this high intake of protein appears desirable. Decreased activity in the aged tends to induce loss of tissue protein. Preservation of protein enzymes and of endocrinal harmony necessary for supporting anabolic processes requires adequate protein nutrition. Also, the aged person usually is able to handle the end products of protein metabolism satisfactorily.

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---

1. Sebrell, W. H. Jr., and Hundley, J. M.: Malnutrition, in Stieglitz, E. J.: Geriatric Medicine, Medical Care of Later Maturity, ed. 3, Philadelphia, J. B. Lippincott Company, 1954, chap. 13.

2. Ohlson, M. A.; Roberts, P. H.; Joseph, S. A., and Nelson, P. M.: Nutrition and Dietary Habits of Aging Women, Am. J. Pub. Health *40*:1101 (Sept.) 1950.

Albanese, A. A.; Higgons, R. A.; Vestal, B.; Stephanson, L., and Malsch, M.: Protein Requirements of Old Age, Geriatrics *7*:109 (Mar.-Apr.) 1952.

Roberts, P. H.; Kerr, C. H., and Ohlson, M. A.; Nutritional Status of Older Women; Nitrogen, Calcium, Phosphorus Retentions of 9 Women, J. Am. Dietet. A. *24*:292 (Apr.) 1948.

Kountz, W. B.; Hofstatter, L., and Ackermann, P.: Nitrogen Balance Studies in Elderly People, Geriatrics *2*:173 (May-June) 1947.

Kountz, W. B.; Hofstatter, L., and Ackermann, P. G.: Nitrogen Balance Studies in 4 Elderly Men, J. Gerontol. *6*:20 (Jan.) 1951.

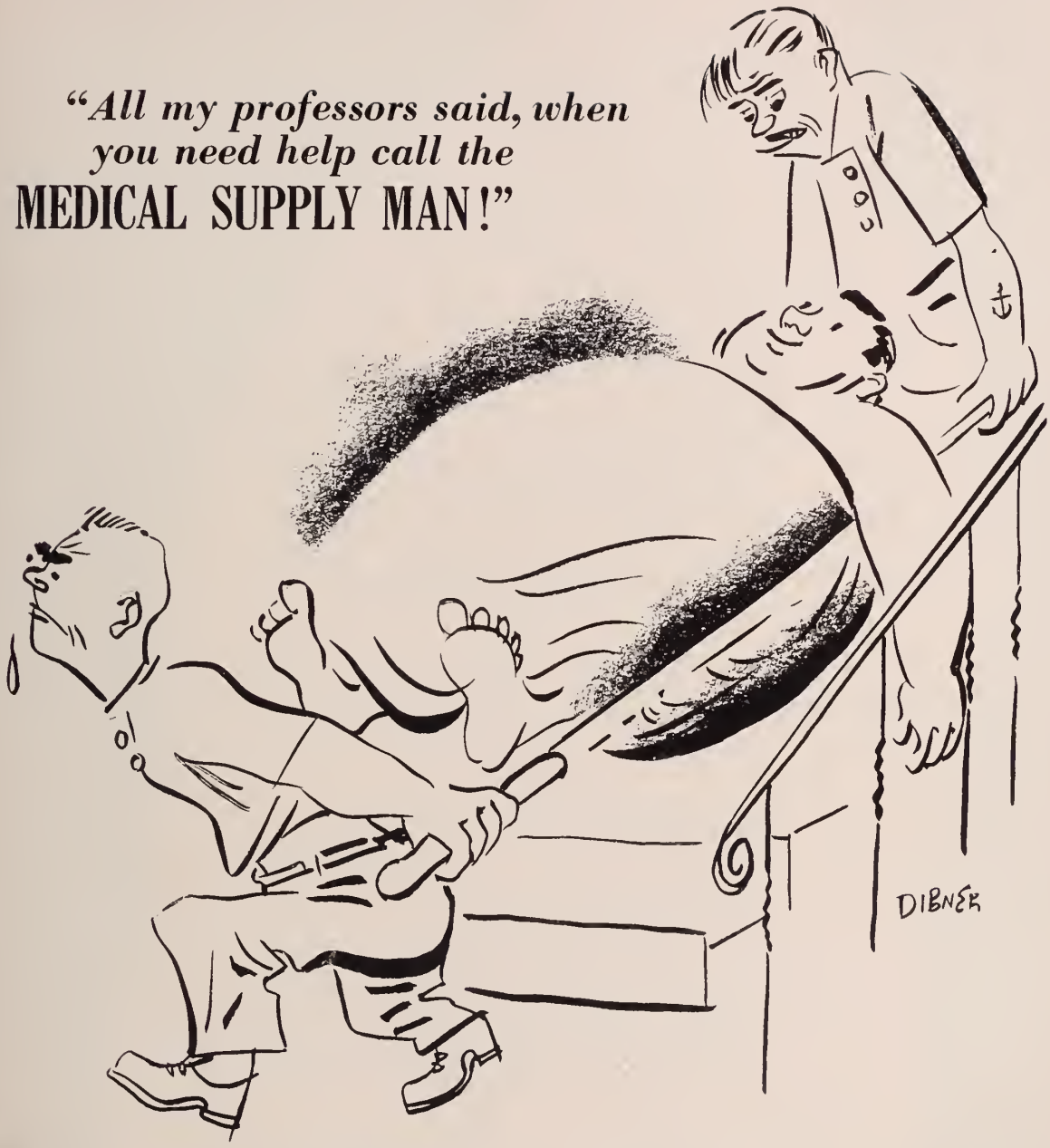
3. Freeman, J. T.: Clinical Correlations in Geriatric Nutrition, J. Clin. Nutrition *1*:446 (Sept.-Oct.) 1953.

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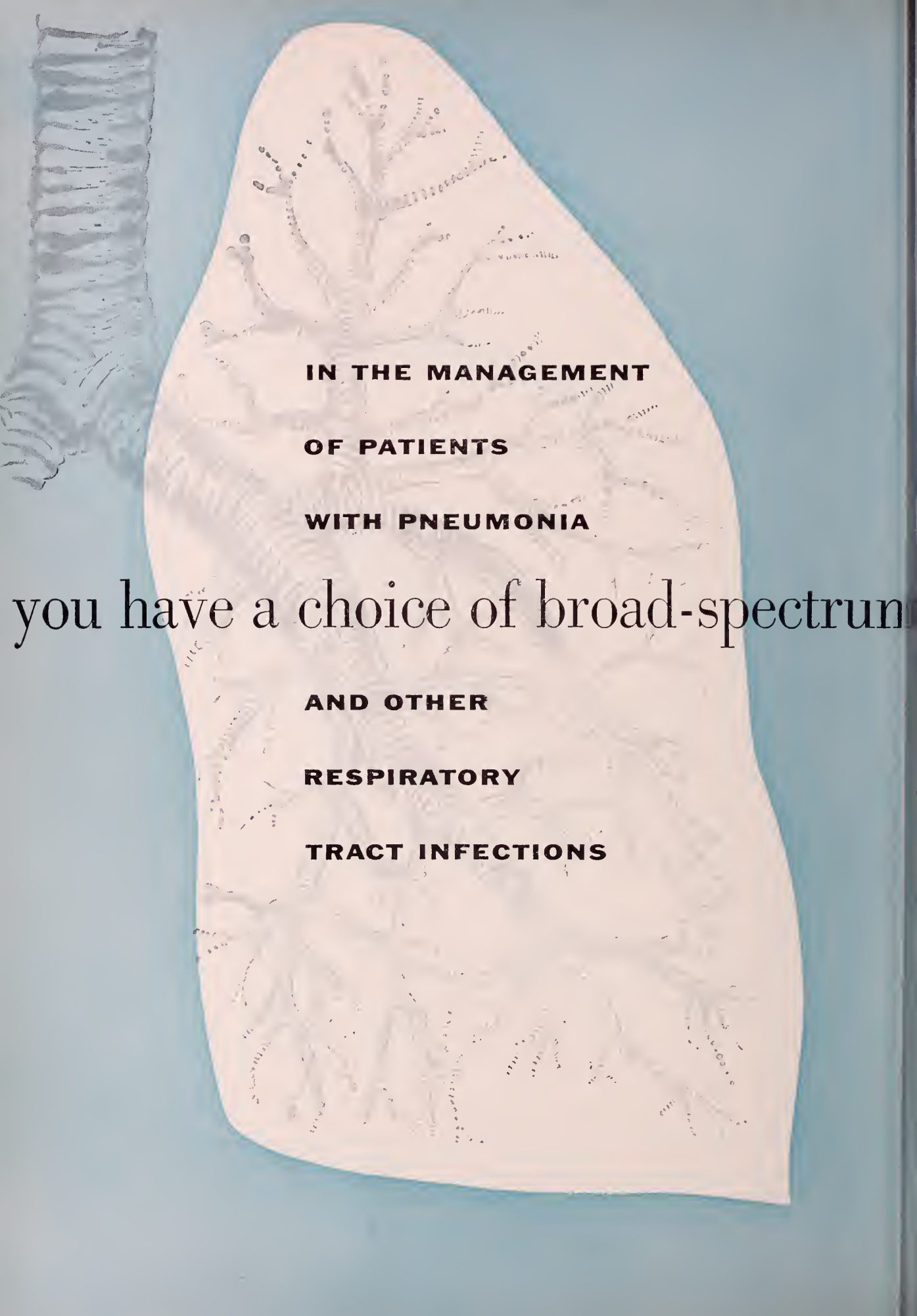
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1. *O'Regan, C., and Schwarzer, S.: J. Pediat. 44:172 (Feb.) 1954.*
2. *Waddington, W. S.; Bergy, G. C.; Nielsen, R. L., and Kirby, W. M. M.: Am. J. M. Sc. 228:164 (Aug.) 1954.*

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	Cochlear damage % of patients		
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Streptomycin	0	0	0
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**Heck, W.E.; Lynch, W.J., and Graves, H.L.: Acta oto-laryng. 43:416, 1953.*

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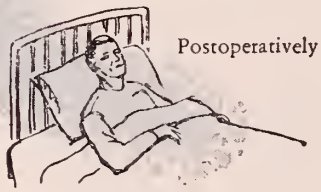
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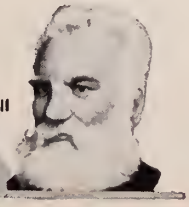
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1. Greenblatt, R. B., and Kupperman, H. S.: M. Clin. North America *30*:576 (May) 1946. 2. McGavack, T. H., in Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc., 1953, p. 225.

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Management of Upper Gastrointestinal Hemorrhage

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CORAL GABLES

The frequency of upper gastrointestinal hemorrhage places this catastrophe as one of the most important emergencies met by the medical practitioner.[1-4] There are still many proponents of a conservative medical regimen; others believe that the surgical approach offers a better method.[5] It is obvious that in a small community lacking a blood bank and a skilled surgeon, fewer lives will be lost by using a conservative regimen. It is the purpose of this paper to stress certain measures that the medical practitioner may use to aid in the management and to stress the importance of teamwork between the medical practitioner and the surgeon. Medical and surgical treatment are complementary, never antagonistic.

This discussion will deal primarily with peptic ulcer as the cause of upper gastrointestinal hemorrhage. The other causes such as esophageal varices, hiatal hernia, gastritis, carcinoma of the stomach, and miscellaneous conditions such as telangiectasis and ulcerative lesions of the small bowel all must be considered when there is no evidence of peptic ulcer.

There are 10 major headings under which the management of hemorrhage will be discussed:

1. Teamwork

One of the first objectives in the care of the patient is joint management through cooperation of a medical-surgical team. The surgeon who sees the patient early will have a base line and will be better able to aid in the decisions to come. He should not be called in after all measures have failed and the patient is in extremis. If, as will be brought out later, the patient should require emergency surgery, the responsibility of the medical member of the team does not stop abruptly. He should go to the operating room with the surgeon and stand by to offer advice to the surgeon. Some surgeons are reluctant to open the stomach and duodenum when no obvious ulcer is present. They either close up after an "adequate" exploratory operation or perform a "blind" gastric resection. Often by opening the stomach a lesion may be seen. At times this lesion is high and easily missed and may not be removed except by a generous resection. There are two other points that the medical practitioner can offer as suggestions to the surgeon: one is the use of a tamponade (esophageal) when bleeding seems to be coming from unsuspected esophageal varices; the other is the use of a tube fed into the duodenum to insure relief of pressure against a weakened duodenal stump in instances in which resection has been performed. When stump closure is difficult and uncertain, it is wise to consider catheter duodenostomy. The surgical staff with which I am associated believes that removal of the ulcer or its exteriorization from the duodenal lumen is imperative though difficult. Recurrent bleeding has occurred when this was not done.

2. Blood Replacement

The use of whole blood, red blood cell suspension, and plasma must be prompt and sufficient. Whole blood should be used during the

Chief, Medical Service, Veterans Administration Hospital, Coral Gables.
Read before the Florida Medical Association, Eightieth Annual Meeting, Hollywood, April 27, 1954.

active bleeding period; however, when bleeding has ceased, the use of red cell suspension is best. The chance of introducing homologous serum hepatitis must always be considered. It is greatest with pooled plasma, less with whole blood, and uncommon after red cell suspension; therefore, one should use the substance least likely to cause this complication. The mortality rate is much higher in homologous serum hepatitis than in acute infectious hepatitis.[6]

When a good blood bank is available, we have three units (1,500 cc.) of blood set aside and usually use 1,000 cc. initially, holding 500 cc. in reserve to be used if evidence of bleeding continues. If active bleeding is still in evidence, the reserve pint is used, and an additional 1,500 cc. is ordered.[7] This procedure is continued until either the bleeding has stopped or a decision in favor of surgical intervention has been reached.

A question that is most frequently raised by interns, residents and house officers is, "How does one tell when active bleeding has stopped?" The answer to this question has been sought for many years, and there is no simple answer. Experienced clinicians feel more secure in their clinical judgment and can tell by observation plus the blood counts what is occurring in most instances. The others hope for some test that will give the answer. It is known that frequent determinations of the hemoglobin, hematocrit and red cell count are helpful, but may give false impressions owing to hemoconcentration or hemodilution. The measurement of the blood volume would certainly tell if there were an easy simple method that could be repeated frequently and be accurate. The use of Aqueous Solution Evans Blue (T 1824) is fairly accurate, but it is inaccurate when repeated at frequent intervals for it is removed by the reticuloendothelial system. Recently, the use of human serum albumin tagged with I^{131} has allowed us to measure plasma volume and blood volume and by subtracting the former from the latter the total packed red cells.[8] This method is said to have the advantage of being accurate when repeated at short intervals and also allowing one to estimate the amount of whole blood or red cell suspension needed so that the circulation will not be overloaded. It has the obvious disadvantage of only being available at those places handling isotopes and as yet has not withstood the test of time.

A simplified method based upon sound physiologic principles has been proposed to aid in discovering those who bleed heavily while under treatment. It is known that pressure in the renal vessels falls before one can record the fall in pressure at the brachial artery level. Renal blood flow is diminished, and therefore urinary output diminishes. By placing an indwelling catheter in patients with massive hemorrhage and measuring the output of urine every hour, at times one can predict early that a hemorrhage has occurred or that shock is imminent. Normally an output of 90 to 150 cc. of urine will be excreted per hour. If this drops to 30 cc. or below, then one knows that the patient is bleeding.

By placing a Levin tube in the stomach attached to suction, one usually obtains blood whenever active bleeding is present either in the stomach or duodenum. When blood no longer is aspirated, it would indicate that bleeding has stopped. At times this procedure may give one a false sense of security. It is not pleasant and may prevent the patient from getting rest. Electrolytic imbalances may also occur due to continued gastric aspirations if it is continued for over 48 hours.

In summary, it is believed wise for one to use all measures available, namely, frequent determinations of pulse, blood pressure, hematocrit, hemoglobin and red blood count, number of stools, et cetera, realizing the degree of inaccuracy. Then in certain instances the measurement of hourly urinary output may be helpful, and finally, if available, the use of serum albumin tagged with I^{131} is apparently an accurate means of determining blood volume as well as an indicator of the amount of blood needed. The use of a Levin tube in the stomach is definitely of value.

3. Sedation

The anxiety caused by a massive hemorrhage is often great. The patient, therefore, should be kept in a drowsy state cut off from any emotional stress. Opium derivatives, particularly morphine, cause delayed emptying of the stomach and at times nausea and vomiting. The use of a barbiturate is preferred. We have used phenobarbital sodium in 2 grain doses every four to six hours with good effect. Occasionally Demerol is used.

4. Feedings

Though the statistics as given by Meulengracht[9] are excellent, I have never thought that feeding all patients is sound judgment. Obviously when a patient is vomiting, he can take little if anything by mouth, and it is best to introduce a

Levin tube. As soon as one believes bleeding has stopped, feeding can begin. Acid digestion of a clot at the site of an ulcer crater may occur; therefore, control of the acidity is important even though the patient did not have ulcer symptoms prior to the hemorrhage.

5. Immediate Treatment of Shock

The use of plasma expanders such as Dextran has been found to be just as valuable as the use of human plasma, and the chance of serum hepatitis does not exist; therefore, this substance can be used while one awaits whole blood. The synthetic antihypotensive drugs such as Levophed and Wyamine may also be helpful and should be available.

6. Location of Site of Hemorrhage

In most instances a careful history and physical examination will suggest the possible cause. A barium swallow is not harmful in most instances; however, a cooperative Radiological Service is essential. Warthin[10] and his group have added a radiologist to the team with improvement in diagnosis. When there is no history of ulcer and no evidence of portal hypertension, fluoroscopy after a barium swallow may be most helpful, particularly if emergency surgery is contemplated. Since peptic ulcer can and frequently does exist in the presence of cirrhosis of the liver, one should not assume that all patients with upper gastrointestinal hemorrhage who have evidence of chronic liver disease are bleeding from esophageal varices. The use of the Bromsulphalein test has been advocated as helpful by White;[11] however, it is not diagnostic. This test may be performed in the presence of bleeding, and if there is retention of the dye (Bromsulphalein) above 15 per cent, one can be fairly certain the patient has liver disease. Esophagoscopy has been advocated as a helpful aid by Palmer[12] in those patients with an enlarged liver. If bleeding is seen in the lower part of the esophagus, one can be fairly certain the site has been located. The presence of spider angioma indicates portal hypertension in over 50 per cent of the cases. In any event one should treat each instance of upper gastrointestinal bleeding as if a peptic ulcer were the cause unless there is indication otherwise.

7. Observation

Except for the utilization of teamwork, frequent observation is the most important item of those listed. The medical physician should use the same principles as used by the obstetricians, that is, "sitting it out" with the patient. Recording the pulse, blood pressure, number and type of stools, as well as keeping account of the blood count, will aid in the decision as to when bleeding has stopped, and when and if emergency surgery is necessary, as well as lessen the anxiety of the patient.

8. Other Medical Measures

Various intragastric instillations have been tried in the hope that local application to the bleeding site will stop the bleeding. The use of topical thrombin with milk as a buffer may be tried.[13] It is difficult to evaluate the results of this procedure, and it is harmless though expensive. Mechanical measures to stop bleeding from esophageal varices have proved to be of definite value,[11] particularly if a balloon is placed in the cardia and inflated with pressure being applied upwards toward the esophagus. In our hands tamponade has been life-saving in many instances.

9. Emergency Surgery

Each instance of massive hemorrhage must be evaluated by itself, and the setting up of dogmatic criteria for emergency surgery, that is, surgery during the active bleeding phase, is dangerous. The following situations have been enumerated which generally indicate the necessity of emergency surgery; they, however, are not to be construed as definite indications:

(1) When a patient does not stop bleeding after 48 hours of careful hospital care as previously outlined.

(2) When a patient who has had a massive hemorrhage manifested by shock again goes into shock due to hemorrhage, regardless of length of time in the hospital under good management.

(3) When a patient has a definite history of severe ulcer distress prior to the hemorrhage and may have a penetrating ulcer on the posterior wall which commonly continues to bleed or may begin again after bleeding has once ceased.

Usually in patients who have had repeated hemorrhages from a peptic ulcer, surgical means of treatment are advisable. These patients should be considered as anyone else in determining the necessity of emergency surgery. Repeated hemorrhage in itself is not an indication for emergency surgery. The advisability of interval surgery is a different decision.

10. When Should Interval or Elective Surgery be Advised?

Some who have written on this subject state that those who have had a gastrointestinal hemorrhage who are over 40 (some say 45, others 50) years of age should have emergency surgery. This conclusion appears to be unfounded by experience. The indications are the same regardless of age. Age and occupation will at times influence the decision regarding interval surgery, but here again individual evaluation is necessary, and strict criteria cannot be laid down. Under the following conditions interval surgery may be justifiable:

(1) When a patient who has had previous gastrointestinal hemorrhages experiences another hemorrhage in spite of good medical management.

(2) When a patient has an ulcer on the posterior wall of the duodenum or a channel ulcer for recurrent bleeding can be anticipated.

(3) When a patient has had one or more hemorrhages and is required by his work to be away from the availability of emergency treatment, as, for example, a merchant seaman.

(4) When a definite ulcer can be demonstrated in a hiatal hernia and the patient has had a severe hemorrhage.

No attempt is made to discuss the type of surgery that should be performed. In our hands a generous gastric resection has been performed in most instances. Gastroenterostomy with vagotomy is gathering more proponents as time goes along. The postoperative complications and sequelae of gastric resection are greater than we would like to see; so as good as it may be, it is far from the ideal treatment of peptic ulcer.

Analysis of Cases

These "ten commandments" of gastrointestinal bleeding are merely those set up at our hospital. There are obvious variations that best fit the individuality of any group. By laying out the course to follow and strictly adhering to this course with only the necessary individual detours, any group can obtain the same or better results. With this thought in mind the accomplishments of the past five years have been analyzed.

In a five year study, from July 1948 to July 1953, there were 302 admissions for the treatment of proved upper gastrointestinal hemorrhage (table 1). The episodes occurred in 255 patients. Fifty-two, or 17 per cent, were due to esophageal varices. One hundred and eighty-two, or 60 per cent, were due to proved peptic ulcer, and in 56, or 18.5 per cent, the cause was not definitely determined in spite of repeated gastrointestinal roentgenograms and in many instances gastroscopic examination. A small group of 12 episodes occurred due to such conditions as telangiectasis, hiatal hernia and one small bowel tumor.

Table 1. — Upper Gastrointestinal Bleeding A Five Year Study

Types	Patients	Number of Episodes
Esophageal varices	38	52
Proved peptic ulcer	158	182
Etiology undetermined	51	56
Miscellaneous group (telangiectasis, hiatal hernia, small bowel tumor)	8	12
Total	255	302

Of the proved peptic ulcers (table 2) 161 were duodenal, 15 gastric, and 6 marginal or gastrojejunal. Emergency surgery, that is, surgery during active bleeding, was required in 17 patients, 14 with proved duodenal lesions and 3 with gastric ulcers (table 3). In 5 instances the cause was not definitely determined either at surgery or, as in 2 instances, even at autopsy. Interval surgery was performed in 22 instances.

Table 2. — Hemorrhage From Peptic Ulcer

Type	Medically Treated	Emergency Surgery	Interval Surgery	Total
Duodenal	131	14	16	161
Gastric	7	3	5	15
Marginal	5	0	1	6
Totals	143	17	22	182

A further breakdown (table 3) shows a group of 143 episodes that by the generally accepted criteria (hemorrhage to cause the hemoglobin to fall below 8 Gm., the hematocrit determination to be below 30 per cent, and the red blood cell count to be below 3 million) are classified as massive hemorrhage. All of the patients requiring emergency surgery fell into this group; 22, or 15.4 per cent, required emergency surgery.

Table 3. — Massive Hemorrhage
(Hematocrit Reading Below 30 Per Cent or Hemoglobin Estimation Below 8 Gm.)

Type	Treated Medically	Emergency Surgery
Duodenal ulcer (proved)	91	14
Gastric ulcer	7	3
Hemorrhage, cause undetermined	23	5

Table 4. — Mortality — Excluding Esophageal Varices

	Number	Deaths	Per Cent
Emergency surgery (during bleeding)	22	7	32.0
Treated medically (surgery not required)	216	4	1.8
Total number of bleeding episodes	238	11	4.6

The mortality shown in table 4 is about the average of most published data except that the mortality among those requiring emergency surgery is a little higher. Analysis of the 7 deaths following surgery (table 5) discloses that preoperative complications were present in 3 instances, and the postoperative complication of a "blown-out" stump occurred in 2 instances. A cardiac arrest was the cause in 1 instance. The problem of the duodenal stump has been solved since now we leave a tube in the duodenum in instances in which the tissue is friable and it does not appear that a good closure is possible.

Table 5. — Medical Deaths

M. G.	No autopsy Clinical diagnosis	1. Hemorrhage, duodenal, due to duodenal ulcer
F. R.	Autopsy findings	1. Ulcer, duodenal, cause undetermined
	Complications	1. Hypertensive — cardiorenal disease
J. D.	No autopsy Clinical diagnosis	1. Pneumonitis, bilateral 2. Ulcer, duodenal, bleeding
W. M.	No autopsy Clinical diagnosis	1. Ulcer, duodenal, with hemorrhage 2. Myeloid metaplasia with hepatosplenomegaly

The 4 deaths occurring in patients not subjected to surgery all were complicated by some condition lethal in itself, namely, barbital poisoning, hypertensive cardiorenal disease with uremia, pneumonia, and myeloid metaplasia with hepatosplenomegaly. In no instance did death occur from hemorrhage alone.

Conclusion

Upper gastrointestinal hemorrhage requires the close teamwork of the surgeon and medical practitioner; the latter should keep as close observation on the patient as the obstetrician should on the patient in active labor. Ten major points are discussed that act as a guide to therapy. Surgery in the active bleeding phase need only be required in 10 per cent of patients with peptic ulcer. Few patients need succumb to this hazard if the patient has a conscientious physician, adequate blood replacement, and a good surgeon. The deaths that result will be those of some irreversible complication.

Appreciation is expressed to Dr. M. H. Todd, Chief of the Surgical Service, Veterans Administration Hospital, Coral Gables, whose cooperation made this teamwork possible.

Miss Pauline Harrington of the Medical Records Library spent many long hours of tedious work in obtaining the statistical material. Mr. Allen Weinberg aided in making and photographing the tables. These services are acknowledged with gratitude.

References

1. Crohn, B. B.: Need for Aggressive Therapy in Massive Upper Gastrointestinal Hemorrhage, J. A. M. A. 151:625-629 (Feb. 21) 1953.
2. Rogers, T. M.: Patient with Upper Gastrointestinal Tract Hemorrhage, J. A. M. A. 150:473-477 (Oct. 4) 1952.
3. Hoerr, S. O.: Management of Bleeding from Upper Gastrointestinal Tract, New England J. Med. 248:404-408 (March 5) 1953.
4. Gott, J. R. Jr.; Smith, E. L., and Dornan, D. D.: Acute Severe Upper Gastrointestinal Hemorrhage: Review of 195 Cases, Ann. Int. Med. 36:1001-1016 (April) 1952.
5. Welch, C. E.: Treatment of Acute, Massive Gastroduodenal Hemorrhage, J. A. M. A. 141:1113-1119 (Dec. 17) 1949.
6. Murphy, W. P. Jr., and Workman, W. G.: Serum Hepatitis from Pooled Irradiated Dried Plasma, J. A. M. A. 152:1421-1423 (Aug. 8) 1953.
7. Ginsberg, V.; Hirshleifer, L.; Ritz, N., and Schwartz, I. R.: Replacement Therapy in Gastro-Intestinal Hemorrhage, Rev. Gastroenterol. 15:747-756 (Oct.) 1948.
8. Kruger, S.; Baker, L., and Mosiman, W. D.: Repeated Blood Volume Determinations in Bleeding Peptic Ulcer, Gastroenterology, 21:516-524 (Aug.) 1952.
9. Rossett, N. E., and Stephenson, S. L. Jr.: Management of Gastro-Intestinal Hemorrhage, Rev. Gastroenterol. 19:379-389 (May) 1952.
10. Warthin, T. A.; Ross, F. P.; Baker, D. V., and Wissing, E.: Management of Upper Gastrointestinal Hemorrhage, Ann. Int. Med. 39:241-253 (Aug.) 1953.
11. Zamcheck, N.; Chambers, T. C.; White, F. W., and Davidson, C. S.: Bromsulphalein Test in Early Diagnosis of Liver Disease in Gross Upper Gastro-Intestinal Hemorrhage, Gastroenterology 14:343-363 (March) 1950.
12. Palmer, E. D.: Observations on Vigorous Diagnostic Approach to Severe Upper Gastrointestinal Hemorrhage, Ann. Int. Med. 36:1484-1491 (June) 1952.
13. Daly, B. M.; Johnston, C. G., and Penberthy, G. C.: Management of Patients with Bleeding from Upper Gastrointestinal Tract with Buffer and Thrombin Solution, Ann. Surg. 129:832-839 (June) 1949.
14. Rowntree, L. G.; Zimmerman, E. F.; Todd, M. H., and Ajac, J.: Intraesophageal Venous Tamponage: Its Use in Cases of Varical Hemorrhage from Esophagus, J. A. M. A. 135:630-631 (Nov. 8) 1947.

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Discussion

Dr. Thomas E. McKell, Tampa: I think it is correct that the close observation of the patient by both physician and surgeon is the one most important factor in saving lives and knowing when emergency surgery must be done. The clinical judgment which one develops from using the laboratory aids and from watching the blood pressure, the pulse and the patient's condition closely, constitutes the most important factor in reaching a decision as to surgery. I should like to ask Dr. Rumball to discuss in more detail the measures which can be used to tell when bleeding has stopped.

Many of these patients are in the older age groups and thus more apt to have coronary disease. They are often in or near shock when seen, and if blood or other agents are not available, may remain so for some time. Because of sedation and shock, they may have none of the classical signs and symptoms of a coronary thrombosis. The electrocardiogram should be added to the diagnostic weapons to be used in the management of a patient with massive hemorrhage.

I should like to emphasize the importance of the use of a barium swallow in the patient with massive hemorrhage. If the radiologist is not immediately available and if the attending physician has any familiarity with and training in the use of the fluoroscope, he should go ahead and give the patient a swallow of sugar barium. A small

Table 6. — Deaths — Emergency Surgery

	Complications		Hospital Day Operation Performed	Postoperative Day of Death	Autopsy	Findings
	Preoperative	Postoperative				
1. M. J. W. Operation Gastrectomy Stomach, duodenum opened	Cortisone Arthritis, severe	Sinus tachycardia Right bundle branch block Hemorrhage	4th	2nd	No	Clinical: 1. Hemorrhage, exsanguinating, gastrointestinal, due to ulceration, stomach and duodenum 2. Arthritis, rheumatoid, severe, extensive, with prolonged cortisone therapy
2. J. S. Operation Gastrectomy	Barrel chest exposure not good	Multiple pulmonary infarcts Atelectasis Acute hepatic necrosis	3rd		Yes	Autopsy: 1. Acute yellow atrophy of liver 2. Ulcer, duodenal, with hemorrhage 3. Pulmonary infarction
3. R. H. Operation Gastrectomy Stomach, duodenum opened	—	Multiple hemorrhages	3rd	6th	Yes	Autopsy: 1. Hemorrhage from duodenal ulcer with arteriosclerosis
4. W. R. G. Operation Gastrectomy Stomach, duodenum opened	—	Peritonitis Renal shutdown Pulmonary congestion	5th	7th	Yes	Autopsy: 1. Bleeding duodenal ulcer, postoperative, with subtotal gastric resection and gastrojejunostomy 2. Perforation, duodenal stump 3. Peritonitis, due to blowout, duodenal stump 4. Renal failure 5. Pulmonary congestion
5. G. W.M. Operation Suture, ulcer area Pylorus opened	Nephrosclerosis Azotemia, moderate	Hemorrhage Uremia Pulmonary edema	4th	5th	Yes	Autopsy: 1. Nephrosclerosis, chronic 2. Azotemia, moderate, due to 1 3. Ulcer, duodenal, chronic, penetrating, bleeding
6. P. B. H. Operation Gastrectomy Stomach, duodenum opened	—	Peritonitis	3rd	7th	Yes	Autopsy: 1. Peritonitis and renal insufficiency due to perforated duodenal stump, postoperative
7. L. C. Operation Not completed	Cardiac arrest Cardiac massage Patient died on table		5th	Day of operation	Yes	Autopsy: 1. Coronary arteriosclerotic heart disease with old infarction 2. Hemorrhage, gastrointestinal tract, probably from ulcerative esophagitis

ulcer often may be demonstrated. I suspect that the percentage of cases in which a diagnosis cannot be made will be lowered by such a procedure.

A most important point is to use no dogmatic criteria. It is certainly true that one cannot let a patient go too long having repeated bleeding. On the other hand, with adequate blood replacement one does not have to set any definite number of hours during which a decision must be made. Close observation of the patient is the best way to decide.

We are often told about the greater risk of hemorrhage in the older age group. Statistically that is true, but a statistic is of cold comfort to the youth 21 years old who dies of a massive hemorrhage because he happens to be one of that 3 or 5 per cent or whatever the figures are. It seems to me that some of the most massive hemorrhages I have seen occurred in persons under 35.

Another point that I should like to cite is the value of the history. The patient without a history suggestive of an ulcer or other disease of the upper part of the gastrointestinal tract, who rather suddenly has a massive hemorrhage, may be under intense nervous strain. If he can be carried through that episode, he may be spared ever having to undergo gastrointestinal surgery since the conditions causing the stress are often so extreme that it would not be expected they would recur. A small acute ulcer or an erosion probably develops which heals rapidly.

In any discussion of elective surgery, the patient whose first symptom of recurrence is hemorrhage must be considered. If he cannot tell when he is beginning to get into trouble so that he can resort to some of the medical measures that are available, he should be offered surgery.

Dr. Chester C. Guy, Chicago: I greatly enjoyed Dr. Rumball's and Dr. McKell's comments on this important and difficult subject. I do not know any more difficult problem for a surgeon than to decide on exploration of a patient who is bleeding from an unknown source in the upper part of the gastrointestinal tract. It may be impossible to find the source, especially when there is no accurate history or findings and one does not know where the bleeding is coming from. I noticed in Dr. Rumball's statistics that in 20 per cent of his bleeding patients the diagnosis was never made as to the source of the hemorrhage. Certainly if the surgeon concludes that the patient must be operated on or he will otherwise bleed to death, then exploration is in order. One must open the stomach and put a finger down into the duodenum, or open the duodenum itself. On more than one occasion I have had the experience of doing that, of finding no ulcer and being unable to palpate any lesion. Being satisfied that the hemorrhage was coming from the stomach, I have gone ahead and performed a subtotal resection, and when the specimen was opened, a small superficial ulcer was found. I also have had other cases in which the specimen showed no ulcer, and the patient continued to bleed and eventually bled to death.

I agree with these gentlemen that there should be no attempt to standardize any formal program of treatment of these cases. Each one is different as an individual problem. The use of the Levin tube for continuous gastric decompression in our hands has been more helpful than the Meulengracht diet and feeding of these bleeding patients. Gastroscopy in our experience has not been helpful. We recommend that any man with a known ulcer, or woman, who has had at least two active hemorrhages be operated on, and particularly if the patient is past 45 years of age.

Dr. Rumball, concluding: In reply to Dr. McKell's question, regarding the ability to know when a patient has stopped bleeding, I can safely say there is no specific method that determines this.

Regarding radiographic examination during the active bleeding phase, one must emphasize that manipulation should not be carried out; however, by filling the stomach with barium little, if any, harm can be done.

Regarding the indications for emergency surgery during the active bleeding phase, I might say that from our experience there appears to be no real contraindication to emergency surgery. I realize that this is a dogmatic statement and might be difficult to defend.

One final point I wish to throw in for controversy is the time-honored division by age of patients who have had gastrointestinal hemorrhage. I do not think statistics will bear out the conclusion that all patients over 40 or 45 or 50 with gastrointestinal hemorrhage should be subjected to surgery. So I will disagree with my good friend, Tom McKell, on this one point. I believe that the age of the ulcer and the amount of scarring surrounding the ulcer crater are more important than the actual age of the patient. On dissecting the pancreatic-duodenal artery or other vessels in the area surrounding a peptic ulcer, one rarely, if ever, sees atherosclerosis in these vessels. In fact, one usually sees a normal vessel. Only the fibrosis of the ulcer itself has caused the artery to be a little more firm, which observation again makes me re-emphasize the point that the age of the ulcer, the amount of the fibrosis, and the size of the ulcer are much more important than the age of the patient.

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Effect of Cortisone on Infections

JOHN P. ROWELL, M.D.
ST. PETERSBURG

It has been about five years since Hench, Kendall, Slocumb and Polley[1] reported on the favorable action of cortisone on rheumatoid arthritis, yet in this time ACTH, cortisone and hydrocortisone have come to occupy a most important place in therapeutics. Their use is becoming more widespread, the cost of the preparations is dropping and production is soaring. In view of the increasing use of ACTH and the corticosteroids it is essential to re-examine some of the basic physiologic effects of these potent therapeutic agents.

The action of ACTH is essentially the same as that of cortisone, but there is a difference in its clinical use. There is a limiting factor in the use of ACTH in that the adrenal cortex is capable of a maximal response but no more, while the effect of cortisone is limited only by the size of the dose. Most of this discussion, therefore, will concern cortisone and hydrocortisone because they have greater capabilities for adverse effects.

It has long been known that cortisone has a deleterious effect on infections. This fact antedated the clinical use of cortisone; as early as 1932 Cushing[2] directed attention to the hypersusceptibility to infections of persons suffering from pituitary basophilism, a condition associated with an increased production of cortical hormones.

In the early animal experimentation Selye[3] noted that large doses of cortisone in the rat predisposed to the formation of pulmonary abscesses and if given at toxic dose levels, it caused fatal systemic infections due to otherwise nonpathogenic organisms. Similarly, Antopol[4] noted that in mice receiving cortisone there developed infections from ordinarily nonpathogenic organisms while control animals in the same cage were not so affected.

Read before the Pinellas County Medical Society, St. Petersburg, June 7, 1954.

In studying the effects of cortisone on bacterial infection Mogabgab[5] injected rabbits with Group A streptococci. Of the 86 control rabbits, 3 died, while of the 85 rabbits treated with cortisone, 78 died. Germuth, Ottinger and Oyama[6] at the National Institute of Health performed experiments on the effect of cortisone on infections in rabbits. They were able to show that cortisone temporarily inhibited the local response to infection (subcutaneous injection of pneumococci); nevertheless, progressive bacteremia and death followed. Tissue studies demonstrated that instead of the usual response to infection (neutrophilic leukocytes, necrosis and thrombosis of small blood vessels), the cortisone-treated animals showed little leukocyte response, and the blood vessels were normal. Bacterial growth proceeded in the tissues, however, followed by seeding into the blood stream and septicemia. They stated: "The most striking characteristic of animals treated with cortisone was a tendency to develop a fulminating bacteremia."

In further tissue studies Ebert and Barclay[7] used the rabbit ear chamber technic with which they were able to observe by direct microscopy a thin layer of vascularized connective tissue. They found that with the use of cortisone, first, vascular tone was better maintained; second, there was a reduction in damage to both arteriolar and venular endothelium regardless of the type of inflammatory stimulus; third, as a result of the increased integrity of vascular endothelium there was a decrease in diapedesis of leukocytes and reduction in exudate. They stated: "If the reactivity of small blood vessels is reduced, it becomes apparent that disease states will be favorably or unfavorably influenced, according to the 'usefulness' of the inflammatory response to the human organism."

Kass and Finland[8] recently reviewed 73 separate studies of infections in animals and sum-

marized as follows: (a) Cortisone and ACTH usually depress resistance of laboratory animals to a wide variety of bacterial, viral, protozoal and fungal agents. (b) ACTH or cortisone may activate latent infections or render animals susceptible to fatal infection by inhabitants of the respiratory or intestinal tracts which ordinarily are nonpathogenic. (c) Depression of resistance occurs regardless of whether the resistance is native or acquired. (d) Effective doses of ACTH or cortisone are usually associated with evidence of increased multiplication of the pathogen, more widespread dissemination and diminished local inflammatory response. (e) Infected animals receiving cortisone or ACTH may succumb to smaller doses of infective agent than do animals not receiving these hormones. (f) When ACTH or cortisone is given in conjunction with antibiotics, the hormones generally reduce the effectiveness of a given dose of antibiotics. (g) The administration of ACTH or cortisone to animals receiving pyrogens generally results in a reduction of the fever. ACTH is hypothermic and reduces fever in resting animals.

There has been little opportunity for comparable clinical experimentation. There have been many short series and isolated reports of cases concerning the deleterious effects of cortisone on infection. In one study of military personnel Hahn and his associates[9] observed 174 patients with acute epidemic streptococcal tonsillitis and pharyngitis. Half were given cortisone, and half were controls. The cortisone group had prolonged fever and leukocytosis with delay in recovery. Armstrong and Irons[10] in 1951 noted "serious bacterial infections (suppurative pericarditis, sinusitis, cortical and renal abscesses) which were clinically unsuspected in patients under treatment for the suppression of inflammatory phenomena in organs other than those in which the infection was found."

The following case is illustrative of a fulminating infection occurring in a patient under treatment with cortisone.

Report of Case

A. V. D., a 37 year old white man, had first had rheumatoid arthritis about six years previously, and had roentgen ray treatments for spondylitis. He was seen in August 1951 for a reactivation of arthritis and was given cortisone and a course of gold injections totaling 1,000 mg., following which he made satisfactory improvement and returned to full employment. In May 1952, he had a recurrence of activity in the left knee which responded to five intra-articular injections of hydrocortisone.

In September 1952, he again noticed a recurrence of symptoms of arthritis, for which he was advised to take 25 mg. of cortisone four times a day. Shortly afterwards a severe sore throat developed. Because the cortisone did not relieve his symptoms as it had previously, he voluntarily took 150 mg. of cortisone daily for a week. At that time, September 24, he had an acute pharyngitis with a leukocyte count of 22,000 per cubic millimeter. The cortisone was discontinued, and he was given 600,000 units of procaine penicillin daily for four days, with apparently some temporary improvement. Four days later he experienced a chill with elevation of temperature to 104 F. and pain in the anterior portion of the chest. A blood culture was obtained, and he was admitted to St. Anthony's Hospital on October 2. This initial blood culture later yielded a slow growth of hemolytic streptococcus, resistant to penicillin.

On admission, the patient complained of pain in the chest anteriorly and shortness of breath.

Physical Examination. — The patient was a well developed, slender 37 year old white man appearing acutely ill. The temperature was 100.8 F., pulse rate 88, and respiratory rate 40. Posteriorly the pharynx was moderately injected. The respiratory excursions were rapid and shallow. The percussion note was resonant over the entire chest, and although the patient complained of some pain of pleuritic type, no rub or rales were heard. The cardiac borders were within normal limits to percussion. The heart tones were distant, and there was a faint systolic murmur heard at the apex. Normal sinus rhythm was present, and no rub was heard. The blood pressure was 120 mm. of mercury systolic and 70 diastolic. The liver and spleen were not felt. There were fusiform swellings of the proximal interphalangeal joints, stiffness of the spine and moderate enlargement of both knees.

Laboratory Data. — Significant laboratory data included a leukocyte count of 21,800, with 28 per cent stab cells, 67 per cent segmented neutrophils, 3 per cent lymphocytes and 2 per cent monocytes, a negative VDRL test, sedimentation rate (Westergren) of 53 mm. in one hour, normal red blood cell count, hemoglobin determination and urinalysis. Roentgenograms of the chest showed the heart to be of normal size and position. There were faint, soft infiltrations throughout both lungs and some obliteration of the left costophrenic angle. An electrocardiogram taken on October 3 revealed the typical elevation of the ST segment, especially in the precordial leads, characteristic of pericarditis, as shown in figure 1.

Course. — The patient was given 1 million units of penicillin every six hours and 1 Gm. of streptomycin every 12 hours plus supportive therapy including an oxygen tent. The septic course continued, with fever spiking to 104 F., rapid respirations and rapid cardiac rate. Pain anteriorly in the chest and the pleuritic type of pain were constant and severe. Pleural friction rubs were noted over both sides of the chest, and in the lungs there developed patches of crepitant rales. The area of cardiac dulness did not change in size, and there was no significant change in the blood pressure. The toxic, febrile course continued. Circulatory collapse gradually ensued, and the patient died at 12:35 a.m. on October 6.

Autopsy. — Postmortem examination was performed by Dr. Luverne H. Domeier. In both thoracic cavities there was approximately 600 cc. of yellowish, murky fluid containing strands of fibrin. The lungs were adherent to the lateral walls of the chest by fibrinous adhesions. Within the pericardial sac, approximately 100 cc. of a yellowish amber, murky fluid was present. In the area around the base of the heart there was a brownish sediment. The pericardial sac was adherent to the anterior and lateral surfaces of the heart by numerous fibrinous adhesions. The heart weighed approximately 380 Gm. The epicardial surfaces were covered by fibrinous exudate (fig. 2). The surfaces were edematous. Within the heart the endocardial surfaces were yellowish gray in color. The myocardium was dark red in color and fairly firm. The coronary vessels and great vessels showed nothing of note. The lungs showed areas of fibrinous tags and adhesions on the pleural surfaces, and on section showed loss of crepitation and consolidation.

Gross diagnoses were: bilateral bronchopneumonia and pulmonary edema; acute fibrinous pericarditis; fibrinous pleuritis, bilateral; hydrothorax; and pericardial effusion.

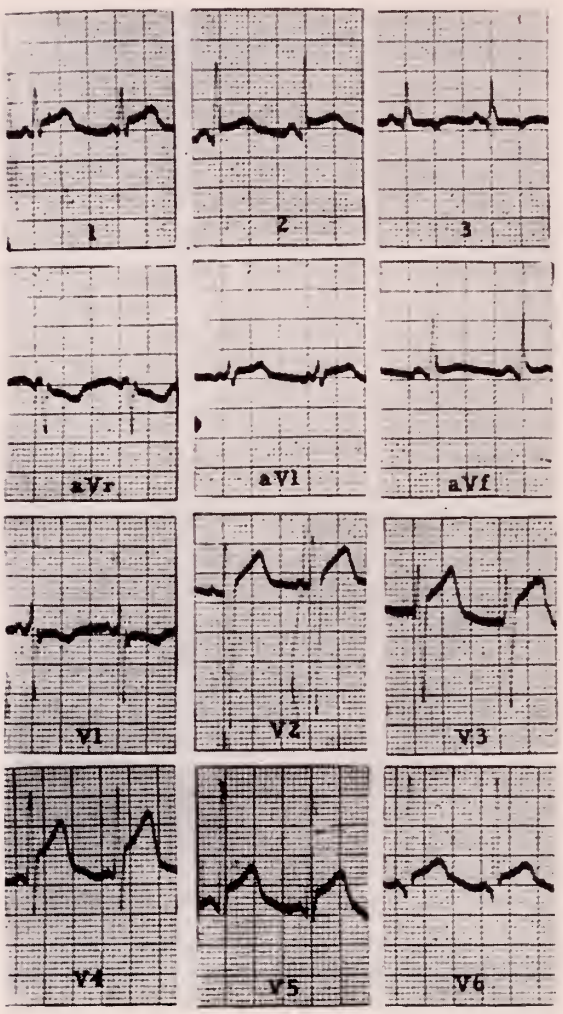


Fig. 1.— Electrocardiogram showing the typical elevation of the ST segment, especially in the precordial leads, characteristic of pericarditis.

Comment

In using the corticosteroids one must keep in mind that they have Dr. Jekyll and Mr. Hyde potentialities. They make the patient with an infection seem better, yet make the infection worse. Many brief reports have appeared extolling the use of cortisone or ACTH as "adjunctive" therapy in severe infections, or as "supportive" therapy in overwhelming infections. It has been advocated in peritonitis, meningococcemia, endocarditis, typhoid fever and other infections. It has been purported to produce 'temporary improvement in the patient's general condition,' and a 'clinical impression of improvement in overwhelming infections.' The concurrent use of antibiotics is of course advocated.

In direct contradiction, Jawetz and Merrill[11] have shown that cortisone decreases the therapeutic effectiveness of antibiotics. The interference with the curative effect applies not only to the bacteriostatic but to the bactericidal drugs. Similarly, Ilavsky and Foley[12] concluded that the antibiotics are unable to complete their therapeutic effectiveness when the normal defense mechanisms have been impaired by large doses of cortisone. Kass and Finland[8] reviewed 313 references and considered the following generalizations warranted: (a) administration of ACTH or cortisone to patients with acute febrile illnesses, or with illnesses characterized by malaise, anorexia and evidence of generalized toxicity frequently leads to prompt defervescence and amelioration of these symptoms; (b) in infections with less prominent symptoms these effects of the hormones are less striking or may be absent; (c) despite the relatively asymptomatic and afebrile state that follows administration of adrenocortical hormones, bacteriologic findings indicate no apparent improvement or even definite impairment



Fig. 2.— The epicardial surfaces of the heart were covered by fibrinous exudate.

in the capacity of the patient to dispose of the offending agent. Bacteremia may develop or persist, bacterial counts in exudates or affected tissues may rise, and the lesions may spread even in the absence of clinical evidence of such adverse effects; (d) antibody production is neither accelerated nor suppressed with doses employed clinically; (e) complications of the infections may occur, although their presence may be masked by the administration of ACTH or cortisone. They posed the interesting question: "If inhibition of inflammation is generally harmful in diseases of known etiology, is it not necessary to examine carefully the premise that such inhibition is beneficial in diseases of unknown etiology?"

Summary

The physiologic effects of cortisone and ACTH in infection are reviewed.

Animal experimentation has been summarized.

A case is presented of a fulminating infection in a 37 year old white man under treatment with cortisone for rheumatoid arthritis.

Generalizations from the available clinical data are presented.

The conclusion is evident that the hazard of infection is great in any patient under treatment with cortisone or ACTH, and clinical awareness of this hazard is essential.

References

1. Hench, P. S.; Kendall, E. C.; Slocumb, C. H., and Polley, H. F.: Effect of Hormone of Adrenal Cortex (17-hydroxy-11-dehydrocorticosterone; compound E) and of Pituitary Adrenocorticotropic Hormone on Rheumatoid Arthritis, Proc. Staff Meet., Mayo Clin. 24:181-197 (April 13) 1949.
2. Cushing, H.: Basophil Adenomas of Pituitary Body and Their Clinical Manifestations (Pituitary Basophilism), Bull. Johns Hopkins Hosp. 50:137-195 (March) 1932.
3. Selye, H.: Influence of STH, ACTH and Cortisone Upon Resistance to Infection, Canad. M. A. J. 64:489-494 (June) 1951.
4. Antopol, W.: Anatomic Changes Produced in Mice Treated with Excessive Doses of Cortisone, Proc. Soc. Exper. Biol. & Med. 73:262-265 (Feb.) 1950.
5. Mogabgab, W. J., and Thomas, L.: Effects of Cortisone on Bacterial Infection, Group A Hemolytic Streptococcal Infection in Rabbits, J. Lab. & Clin. Med. 39:271-289 (Feb.) 1952.
6. Germuth, F. G. Jr.; Ottinger, B., and Oyama, J.: Influence of Cortisone on Evolution of Acute Infection and Development of Immunity, Bull. Johns Hopkins Hosp. 91: 22-47 (July) 1952.
7. Ebert, R. H., and Barclay, W. R.: Changes in Connective Tissue Reaction Induced by Cortisone, Ann. Int. Med. 37:506-518 (Sept.) 1952.
8. Kass, E. H., and Finland, M.: Adrenocortical Hormones in Infection and Immunity, Ann. Rev. Microbiol. 7:361-388, 1953.
9. Hahn, E. O., and others: Effect of Cortisone on Acute Streptococcal Infections and Post-streptococcal Complications, J. Clin. Investigation 30:274-281 (March) 1951.
10. Armstrong, S. H. Jr., and Irons, E. N.: Physiological Considerations of ACTH and Cortisone Therapy With Reference to Ophthalmology, A. M. A. Arch. Ophth. 45:251-257 (March) 1951.
11. Jawetz, E., and Merrill, E. R.: Effect of Cortisone Upon Therapeutic Efficacy of Antibiotics, Science 118:549-550 (Nov. 6) 1953.
12. Havsky, J., and Foley, E. J.: Observations on Antibiotic Treatment of Bacterial Infections of Cortisone-Treated Mice, Proc. Soc. Exper. Biol. & Med. 84:211-214 (Oct.) 1953.

Medical Square Building.

Four Decades of Otolaryngology

Mozart A. Lischkoff, M.D.

PENSACOLA

In the spring of 1912, shortly after beginning to practice ophthalmology and otolaryngology in a small community, I was asked to treat a man who had a piece of bone lodged in his esophagus. I suggested a direct examination with an endoscope, and it took me longer to explain the procedure and convince my medical colleagues than to remove the foreign body. It created local medical history. A similar episode today would be routine, and the patient's family would probably call the otolaryngologist direct and advise that someone needed an esophagoscopy.

No branch of medicine has progressed more markedly than otolaryngology; a few years ago many feared it might disappear with the advent of the antibiotics, biochemicals, and antihistaminics. The introduction of the sulfonamides gave rise to a changed viewpoint. Some thought it was to be a declining specialty of nonoperating surgeons; instead it has progressed and challenged the skill and imagination of the profession and through research has become vigorous and expansive.

As medical knowledge and technics expanded beyond the capabilities to master them all, surgeons became skillful in a few procedures and some became specialists by public acclaim.

Toward the end of the nineteenth century increasing numbers of physicians began to flock to the new specialties of Ophthalmology and Otolaryngology although there were no training facili-

President's Address.

Read before the Florida Society of Ophthalmology and Otolaryngology, Fifteenth Annual Meeting, Hollywood, April 25, 1954.

ties available; some learned by assisting those few who had pioneered or gone to Vienna or Berlin, where lectures and demonstrations were available. Although the New York Eye and Ear Institute was founded in 1820 and was the first specialty hospital in America, it had no training facilities. The first ear clinic on record was credited to Adam Politzer of Vienna in 1873; here many of the renowned European and American specialists received their training. In 1903 the University of Illinois scheduled a course in Otolaryngology under Ballenger; it was for two hours a week for four months. Beck in Chicago offered courses of one hour a week for 10 weeks which included pathology. About the same time Dr. Harris P. Mosher on his return from Europe started a graduate course at Harvard Medical School. He said his students worked from 9 a.m. to 10 p.m. and that his graduates were prouder of that than of what they learned.

The course now consists of one year in basic science and two years of research in Otolaryngology. Sluder and Sauer gave courses at Washington University in St. Louis for 30 hours; they repeated them in 1913 for two hours daily, for a fee of $25. Before then a general practitioner became a specialist by announcement, after he had attended a clinic for a brief time.

In 1910, surgery of the ear, nose and throat consisted of procedures on the tonsils, turbinates, mastoid and septum. Many cases of maxillary sinusitis were of dental origin and were treated by dental extraction and lavage, instead of by the nasal approach, resulting in oroantral fistulas. The cure by sublabial approach helped popularize the Caldwell-Luc operation. Some of the outstanding otolaryngologists avoided the submucous resection, and preferred not to work through a buttonhole incision. Partial or complete turbinectomy or galvanocautery was utilized to increase breathing space. The submucous resection demonstrates the difference between biologic conservation and destruction or impairment of function.

Many of the laryngectomies were performed by general surgeons with or without help from the laryngologists. Most tonsil and adenoid operations were performed in the office, as hospital facilities were not available, nor were they considered necessary for such operations. Ear, nose and throat surgery was performed in the doctor's office, and few patients were hospitalized. Preoperative medication did not appear important. Tonsillectomies were replacing the Mackenzie guillotine operation, which was frequently performed in bathrooms and kitchens. It was common practice to go to the patient's residence in a horse and buggy, have a nurse, or helper, pour ethyl chloride or a few drops of chloroform on a handkerchief or towel, hold the child until overcome by the anesthetic, then with a quick clip take out one tonsil, then the other. This procedure was followed by rapid curetting of the nasopharynx, and the surgery was complete.

Most hemorrhages seemed to be self-limited. In those days tonsillectomies had not acquired the status of major surgery. They were performed on the European continent in mass production even after World War I.

In 1924 a small group of leading otolaryngologists organized a committee to pass on the qualifications of those practicing the specialty, and it met with resistance as many saw no need of it. Today board certification is as important as training, and is the aspiration of all. It labels those who accept it with a sign of modern knowledge as distinguished from technical primitiveness. Not many years ago, an imposing equipment suggested great skill in a small limited field and might have included a limited mental horizon.

The specialty developed from a narrow viewpoint. The ear and larynx were treated as independent organs until they were accepted as and became integral parts of the human economy.

Otolaryngology now accepts the principle that the ear, nose and throat are parts of the human body and require general consideration and that many otolaryngologic disorders are local manifestations of systemic conditions.

Advances in Otology

The greatest advance in Otology has been in the treatment of otosclerosis. About 1916 Holmgren began working on the idea of fenestration for relieving deafness, but Barany of Vienna, having observed improved hearing in several fistula cases, anticipated fistulizing the cochlea at that time.

Sourdille in France and Lempert in this country pioneered in developing and perfecting the operation for otosclerosis. The origin of the fenestration operation, formerly known as the window operation, dates back to 1896 when Passow of Germany suggested a surgical approach. In 1904, Barany laid the groundwork for this operation by his studies of fistulas in the bony semi-

circular canals. Holmgren in 1920 performed the experimentation in connection with the surgical relief of otosclerosis; his fistulas did not remain open.

There were many experiments with different approaches, until Lempert in 1938 modified the procedure into a one stage operation which was a great improvement. Others continued, but the nov-ovalis perfected recently appears to be the most satisfactory surgical means of restoring hearing. In this procedure the fistula remains open in a large percentage of cases.

A department of neuro-otology at the University of Pennsylvania under Lewis Fisher was created in 1912; it was, I believe, the first of its kind, and much of this information was put into practical usefulness at Mineola and other research centers in World War I. This knowledge was translated into aviation medicine, from which the flight surgeon evolved.

Endoscopy is for practical purposes recent. Killian in 1911 demonstrated suspension laryngoscopy while Lynch perfected it in this country. Our guest of honor, Dr. Francis E. LeJeune, is the world's authority on this subject.

The use of iodized oil and radiopaque substances was first employed in 1927 to visualize the lower air passage as an aid to the diagnosis of bronchopulmonary disease. The chest surgeon in many instances is a diagnostic bronchoscopist, in that he does not depend on the otolaryngologist for endoscopy.

The otolaryngologist is from training better able to deal with structures surrounding and relating to the larynx, trachea and upper part of the esophagus. He is trained to work in a small field and has developed monocular vision. He should be prepared to treat periesophageal infections and perforation of the cervical esophagus and mediastinal emphysema, all of which may be complications of esophageal and bronchial conditions.

Pharyngeal diverticulum is an excellent example of the combined endoscopic and external surgical procedures by this knowledge. This field has expanded from foreign bodies to bronchogenic tumors, pulmonary abcesses, atelectasis, and a large category of conditions included in the field of bronchology.

By the end of the first decade of the century men like Fletcher and Sonnenschein spent two or more years in Europe, one in Vienna and another with Gerber in Königsberg. It was here that Robert Sonnenschein did the work on which he based his erudite studies of the Schwabach test. The men being trained today do not fully appreciate the value of the tuning fork. One appreciates the audiometer much better with a tuning fork background. The Edelman forks and whistles were officially presented to the profession in 1890, but not popularized until 1908. The tests are standard and valuable in diagnosis to those familiar with their technics. Most otologists use the audiometer, which gives a written record of the hearing, and the examination can be performed by a nonmedical technician. Although the audiogram is the most accurate record of hearing loss, courts of law do not accept this record as evidence. The first audiometer in practical use was the pitch range type designed by Bunch in 1919, quite a contrast to the accurately calibrated precision instrument for individual or mass screening in the detection of poor hearing.

The military services have created centers for rehabilitation of the hard of hearing and have taken the lead in this important condition; today audiologists are directing their attention to the problem of deafness and formulating programs of therapy which give great promise.

The Broadening Concept

It is said that Otolaryngology is at the crossroads; it is maturing into a major specialty and includes reconstructive plastic surgery of the head and neck, bronchoesophagology, fenestration, allergy and cancer. The sinus problem has been changed by the allergic studies of Hansel and his followers. Allergy is the term accepted to denote hypersensitivity.

We emphasize early investigation of hoarseness, yet hundreds of cases of laryngeal carcinoma come to early grief because of neglect.

In 1931 petrositis was revealed as an entity and understood both in regard to the pathology and surgical drainage; yet it has almost vanished while we have Menière's disease, understood as hydrops of the labyrinth, for which there is no satisfactory medical control.

Specialization has many advantages, and its accomplishments have justified its existence. It is said that "specialization may not be most desirable but the cooperation of specialists in innumerable over-lapping departments has effected changes in the structure of medicine and surgery, greater and more lasting than anything previously known." Every specialty will overlap and share

interest with other specialties, general medicine, and surgery; but conflict will be minimized with tolerance and cooperation so that our knowledge will be increased to be of benefit to the patient.

Wangensteen said: "There are still a few surgeons who effect to believe that they can take all surgery for their province. They know as well as anyone that their performance in such a wide category of operating procedure is sub-standard in some of these areas, when judged in the critical light of what constitutes good practice."

There is great satisfaction in observing this panorama, and it is hoped that the advances in atomic medicine, the impetus of radioisotopes, and ultrasonic research will result in unlimited scientific achievements. It is desired that the otolaryngologist continue his high ideals so that he can practice the art as well as the science of medicine.

404 Blount Building.

Atypical Constriction of the Aorta Report of a Case

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JACKSONVILLE

There has lately been a renewal of interest in the diagnosis of congenital cardiac anomalies because of the surgical advances made in this field. Coarctation of the aorta is one such remediable defect, but the condition still often goes undetected even though the diagnosis can easily be made. Its recognition depends on constantly keeping the possibility of this condition in mind and carrying out the simple procedures of palpating the pulses in the abdominal aorta and the lower extremities.

Diagnosis

In the diagnosis of this disease entity, the history will not be of specific value as there is no typical set of symptoms that would lead one strongly to suspect the presence of coarctation. The symptoms are usually minimal and due to the hypertension, namely, headaches, dizziness, dyspnea and palpitation, or to the decreased circulation in the lower extremities, namely, numbness, coldness, cramps and decreased wound healing.

The diagnosis is made on the basis of the physical and roentgen findings. The physical signs that should arouse suspicion are: (1) Hypertension, especially when associated with dilatation of the ascending aorta and conspicuous pulsations in the episternal notch. (2) Collateral circulation as manifested by enlarged, tortuous, superficial arteries of the chest and back, a murmur in the interscapular area when none is audible over the precordium, visible or palpable pulsations in the interscapular or posterior axillary areas, and murmurs and thrills in abnormal locations. (3) Coldness of the feet with absent or decreased pulsations.

The constriction of the aorta results in increased blood pressure in the vessels supplying the arms and head. The blood reaching the lower part of the body is carried chiefly by anastomotic vessels, and as a result the blood pressure in the vessels of the lower portion of the body is low. Friedman, Selzer and Rosenblum,[1] however, and Steele and Cohn[2] believed that the hypertension produced in this disease entity is probably due to the slowing and diminishing of blood supplied to the kidney, causing a renal ischemia. The type of hypertension is not distinctive. It may not be persistent, and the blood pressure may even be normal. Taussig[3] recorded 4 cases in which the patients were between 8 and 35 years of age with a blood pressure of 140/90 or below, and Hines and Christensen[4] mentioned 2 cases in which the patients were 8 and 42 years old with normal blood pressures. The blood pressure in the legs is often absent, but when present, the systolic pressure is always lower than in the arms, but the diastolic pressure may at times be higher. This phenomenon was exhibited in the case presented by

Railsback and Dock[5] in which there was a blood pressure of 190 90 in the arms and 164 140 in the legs.

The roentgenogram often reveals a notching of the inferior surface of the posterior ribs due to the dilated intercostal arteries. When this is seen, it is usually pathognomonic of coarctation of the aorta. At times in adults, however, this notching may be absent or so inconspicuous that it is easily overlooked. When notching of the ribs is not present, angiocardiography and aortography are of great value in confirming the diagnosis. By these methods, the constricted portion of the aorta may be localized and the length and caliber of the constriction estimated. Freeman, Miller, Stephens and Olney[6] believed they obtain better visualization of the constriction by means of arteriography wherein the radiopaque substance is injected into the common carotid artery in a retrograde fashion.

The electrocardiogram shows no specific changes.

Types of Coarctation

The term "coarctation of the aorta" is often thought of as being limited to the classical constriction of the aorta, near the site of junction of the ductus arteriosus. Two types of coarctation of the aorta exist at this site, the infantile and the adult. The infantile type is composed of a generalized wide constriction involving the area between the left subclavian artery and the point of entrance of the ductus arteriosus. There are often other significant cardiac defects accompanying this type. The adult type is usually characterized by an abrupt localized constriction at or near the entrance of the ductus arteriosus. The caliber of the lumen of the constricted portion may vary greatly in either type, and it is most difficult at times to differentiate them clinically. The infantile type, however, is usually incompatible with long life.

Stenosis of the thoracic aorta may also occur in atypical locations. Bahnson, Cooley and Sloan[7] demonstrated by angiocardiography 2 cases of aortic stenosis distal to the ductus arteriosus, one in the midthoracic aorta and the other below the renal arteries. They also collected from the literature 10 other cases of coarctation below the ductus arteriosus, in 1 of which a thoracolumbar sympathectomy had previously been performed. There are apparently two different types; when above the diaphragm, the constriction is more diffuse, while below the diaphragm it is usually at or just below the level of the renal arteries. Coarctation of the aorta with hypotension in the left arm has been reported by Burchell, Taylor, Knutson and Wakim,[8] due to the developmental anomaly involving the left subclavian artery.

One case of stenosis of the thoracic aorta was studied with the following interesting points being noted: (1) the age of the patient, (2) the lack of symptoms, (3) the unusual site of the aortic constriction, and (4) the absence of any prominent collateral circulation.

Report of Case

Miss C. R., a 73 year old white woman, was seen for nonsymptomatic hypertension. Her blood pressure was recorded first approximately 20 years previously, at which time the systolic pressure was 230 mm. of mercury. Since then the blood pressure has continued to range between 210 and 240 mm. of mercury. She has had no headaches, dizziness, shortness of breath, pain in the chest, palpitation or edema. She has had no leg cramps, but her feet easily become cold.

There was a history of mumps and pertussis in childhood, measles at the age of 20 and rubella in 1917. Operative correction of an ununited fracture of the left ankle in December 1945 was followed by fracture of the left forearm in April 1950. About 20 years before this examination she had had a chronic recurrent asthmatic bronchitis, which was cured by an autogenous vaccine. Somewhat later, she had also had pleurisy of one week's duration.

The physical examination revealed a well developed and well preserved white woman not acutely ill. The heart was not enlarged; there was a regular rhythm at a rate of 68 beats per minute. The sounds were of fair quality, and no murmurs were heard. The blood pressure was 245 systolic and 120 diastolic in both arms. There were no signs of congestive failure. No abdominal aortic, femoral, popliteal, posterior tibial or dorsalis pedis pulsations were obtainable, nor could the blood pressure be recorded in either leg. There was no evidence of superficial collateral circulation present. The ophthalmalogic report follows: "The visual acuity of the right eye was reduced to 10/200 and that of the left to 20 100. This corrected to 20/100 in the right and 20 50 plus in the left. The visual deficiency is due to the development of a cataract in each eye. There was moderate vascular sclerosis but not unusual in a person of this age." The remainder of the physical examination showed no other significant deviations from normal.

The laboratory studies, which included a complete blood count, serologic examination, and stool examination, gave negative results. Urinalyses gave normal results except for occasional traces of albumin. The nonprotein nitrogen was 37 mg. per hundred cubic centimeters, the phenolsulfonphthalein excretion was 55.5 per cent in two hours, and the urine concentrated to 1.021. A roentgenogram of the chest was reported as being essentially normal with no notching along any of the rib margins. The electrocardiogram revealed a right bundle branch block.

Since the diagnosis of coarctation of the aorta could not be substantiated by roentgenograms of the chest or the presence of collateral circulation, an arteriogram was made with the aid of Dr. A. Judson Graves, who reported: "The x-ray examination of the chest was carried out by a series of views made only in the lateral position. The patient was placed at the chest stand and 40 cc. of 50 per cent Neo-Iopax was injected intravenously in a rather rapid fashion. The first x-ray exposure was made just at the completion of the injection and two additional films were made in rapid succession following the first exposure.

"In the first x-ray film (figs. 1 and 2) one sees clearly the aortic shadow as it 'takes off' from the left ventricle. The aortic curve is beautifully demonstrated and is clearly seen as it comes to a point about 2 inches above the dome of the diaphragm. At this point, one sees a definite narrowing as if some pinch-cock arrangement was placed over the make-up of the aorta. There is a U-shaped indentation on the posterior wall and a much greater U-shaped indentation on the anterior wall of the aorta at the described point some 2 inches before it goes through the diaphragm. The degree of anterior curvature in the aorta extends for at least a 2 inch distance, and thus the encroachment on the lumen of the aorta is well seen and adequately demonstrated.

"Although the margins of the aorta are not nearly as sharply outlined distal to the constriction, I do feel we are able to see the aortic wall distal to the area of involvement, and it appears to expand just before it passes through the diaphragm."

Surgical therapy was not considered because of the patient's age and the lack of symptoms.



Fig. 1. — Lateral roentgenogram of the chest demonstrating constriction of the lower part of the thoracic aorta.

Discussion

The etiology of the constricted aorta of this type is obscure. Several theories have been advanced. Some authors implicate syphilis and rheumatic fever, while others consider the condition embryologic in origin. In the case presented, it is impossible to arrive at any definite conclusions as to origin without pathologic studies. The constriction possibly was related to the infection of the lung and pleurisy which occurred just prior to the first recording of the patient's blood pressure 20 years earlier, but probably it was congenital.



Fig. 2. — Constricted portion of the thoracic aorta is outlined for better visualization. The dark shadow anterior to the aorta is a bronchial marking.

Until the last few years, there has been no definitive therapy in cases of coarctation. In 1945 Crafoord and Nylin[9] and Gross and Hufnagel[10] independently reported the successful surgical correction of coarctation of the aorta. In this operation there is an excision of the constricted area with an end to end anastomosis of the resected aorta. The presence of well established collateral circulation makes it possible to clamp off the aorta for the period of time necessary to complete the operation without interfering with the circulation of the lower part of the body. Blalock and Park[11] developed an operation to bypass the area of constriction by anastomosis of the carotid or left subclavian artery to the descending aorta. This operation is of value in cases unsuited to end to end anastomosis, such as the infantile type, or in those in which the constriction arises too close to the base of the subclavian artery.

Operation seems well justified in cases of extreme hypertension. In the milder cases, there is no uniformity of opinion as to the advisability of surgical intervention, but the trend apparently

is toward a more liberal selection of operative cases. The average age at death in all cases of adult type of coarctation of the aorta is about 35 years. The studies of Newman,[12] however, indicate that the prognosis is not too bad if symptoms do not appear until after the age of 20 years. Severe hypertension may sometimes last for many years without causing heart failure, and some patients may live a normal span of life. Surgical treatment should be performed in youth; first, because of the increasing death rate with the increasing years from the complications of rupture of the aorta, bacterial infection at the site of coarctation, cerebral hemorrhage, and congestive failure; second, because the operation becomes technically impossible in the presence of pronounced sclerosis and calcification of the aorta; and third, because in older persons, some residual elevation of blood pressure may remain after operation. Probably the most favorable period for operation is between 13 and 18 years of age. Sokolov,[13] however, recently reported the operative correction of a coarctation in a man of 40, and Blalock,[14] in his discussion of Gross' paper, reported a successful result in a man of 41 years. At the other extreme, Kirklin and his associates[15] reported the successful resection of the segment of aorta containing the coarctation in a 10 week old infant with disappearance of evidence of coarctation and of left ventricular failure.

From this survey it is realized that, although in most of the cases of coarctation of the aorta coming to surgery the stricture will be of the typical adult type located at or near the ductus arteriosus, rare cases of the infantile type and of stenosis in atypical locations will occasionally be encountered, making it essential to determine the exact localization preoperatively in all cases. The degree and level of the coarctation often will determine the approach and the type of anastomosis the surgeon will use.

Summary

The clinical picture of adult and infantile coarctation of the aorta is outlined.

Stenosis of the thoracic aorta may occur in atypical locations.

A case of stenosis of the aorta just superior to the diaphragm in a 73 year old white woman is recorded.

Surgical procedures are outlined, but intervention was not considered in this case because of the patient's age and the relative lack of symptoms.

References

1. Friedman, M.; Selzer, A., and Rosenblum, H.: Renal Blood Flow in Coarctation of Aorta, J. Clin. Investigation 20:107-111 (March) 1941.
2. Steele, J. M., and Cohn, A. E.: Nature of Hypertension in Coarctation of Aorta, J. Clin. Investigation 17:514 (July) 1938; also, Steele, J. M.: Evidence for General Distribution of Peripheral Resistance in Coarctation of Aorta: Report of 3 Cases, J. Clin. Investigation 20:473-480 (Sept.) 1941.
3. Taussig, H. B.: Congenital Malformations of the Heart, New York, Commonwealth Fund, 1947.
4. Hines, E. A. Jr., and Christensen, N. A.: Diagnosis and Prognosis in Cases of Coarctation of Aorta, Proc. Staff Meet., Mayo Clin. 22:121-124 (April 2) 1947.
5. Railsback, O. C., and Dock, W.: Erosion of Ribs Due to Stenosis of Isthmus (Coarctation) of Aorta, Radiology 12:58-61 (Jan.) 1929.
6. Freeman, N. E.; Miller, E. R.; Stephens, H. B., and Olney, M. B.: Retrograde Arteriography in Diagnosis of Cardiovascular Lesions; Coarctation of Aorta, Ann. Int. Med. 32:827-841 (May) 1950.
7. Bahnson, H. T.; Cooley, R. N., and Sloan, R. D.: Coarctation of Aorta at Unusual Sites; Report of 2 Cases with Angiocardiographic and Operative Findings, Am. Heart J. 38:905-913 (Dec.) 1949.
8. Burchell, H. B.; Taylor, B. E.; Knutson, J. R. B., and Wakim, K. G.: Coarctation of Aorta with Hypotension in Left Arm; Physiologic Observations on Direct Intra-arterial Pressures and Flow of Blood, M. Clin. North America 34:1177-1185 (July) 1950.
9. Crafoord, C., and Nylin, G.: Congenital Coarctation of Aorta and Its Surgical Treatment, J. Thoracic Surg. 14:347-361 (Oct.) 1945.
10. Gross, R. E., and Hufnagel, C. A.: Coarctation of Aorta; Experimental Studies Regarding Its Surgical Correction, New England J. Med. 233:287-293 (Sept. 6) 1945.
11. Blalock, A., and Park, E. A.: Surgical Treatment of Experimental Coarctation (Atresia) of Aorta, Ann. Surg. 119:445-456 (March) 1944.
12. Newman, M.: Coarctation of Aorta; Review of 23 Service Cases, Brit. Heart J. 10:150-157 (July) 1948.
13. Sokolov, R. A.: Coarctation of Aorta with Surgical Correction at Age 40; Report of Case, J. A. M. A. 148:641-642 (Feb. 23) 1952.
14. Gross, R. E.: Surgical Treatment for Coarctation of Aorta; Experiences from 60 Cases, J. A. M. A. 139:285-292 (Jan. 29) 1949.
15. Kirklin, J. W., and others: Surgical Treatment of Coarctation of Aorta in Ten Week Old Infant; Report of Case, Circulation 6:411-414 (Sept.) 1952.

Medical Arts Building.

Eighty-First Annual Meeting

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Trends in Treatment of Allergic Conditions: Pediatric Aspects

W. AMBROSE MCGEE, M.D.

WEST PALM BEACH

Conditions as complex and varied as allergic disorders naturally lead to a variety of signs and symptoms, differences of opinion and a multitude of measures and drugs for management.

In early infancy, when allergic symptoms are incorrectly considered infrequent, judicious feeding and care often enable the pediatrician to recognize potential allergy in its incipiency and to undertake measures to reduce the incidence and severity of future allergy. Drugs, in that age group, while useful, are of much less value than dietary measures. The slow introduction of single foods and synthetic vitamins, with two waiting periods of five then three days, quickly enables him to detect potential allergy. Rapid feeding of new and multiple foods at an early age does not permit recognition of allergic-like signals.

Since the introduction of antibiotics there has been an enormous use of these drugs not only for infectious diseases but likewise for many types of allergic disorders, especially those of the respiratory tract. Not only does such procedure lead to more and more sensitivity to the antibiotic itself, but antibiotics as a whole have not been shown to be particularly effective against definite virus infections, and indiscriminate use of them leads to a decrease in their effectiveness against certain bacteria. In respiratory allergic disorders antihistamines and epinephrine play a big part. The early use of such remedies may often abort or ameliorate respiratory disturbances. Epinephrine by hypodermic in repeated small doses, as 2 to 4 minims, is far better in childhood than a single larger amount. Small localized areas of pulmonary consolidation beneath mucus plugs, when treated early, will often respond dramatically to epinephrine alone, and the pneumonia rapidly clears up. When small doses of epinephrine fail to give relief, aminophylline suppositories have proved to be satisfactory and most efficacious.

Unfortunately the element of claustrophobia enters the picture when some children require oxygen therapy. There seems to be more and more question as to the value of oxygen therapy in asthma. Whether or not it is efficacious, per se, it does insure an air-conditioned area which is most helpful for inhalant sensitivity. The new Alevaire for aerosal inhalation so far seems to be an excellent product, but, unfortunately, the apparatus necessary is expensive and mechanically difficult to set up.

The use of antigens for hyposensitization for inhalant offenders varies widely in different hands and in different localities. Some allergists, for example, treat so-called fall hay fever problems with ragweed alone, or grass-sensitive patients with timothy alone. It is my belief that better results are obtained when multiple local pollen offenders are included in the antigen along with other multiple inhalants as molds and epidermals. Likewise, there are advocates of both high and low dose pollens or other inhalant antigens. To me the optimum dosage is based on that dose which gives the greatest protection with the least potent antigen and the smallest quantity. In my experience, I have seen many variously sensitive persons who cannot tolerate an antigen stronger than 1 to 50,000,000 dilution without getting some type of mild reaction.

While there is no agreement as to seasonal or perennial treatment, it is my routine to use the perennial method. In definite seasonal cases, once the tolerance dose is established, I prefer weekly injections during the season, and between seasons, injections as far apart as three weeks if the patient can be symptom-free for that period of time. While treating for pollens in such cases, I include other inhalants to which there is a positive

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reaction which are relevant to the area in which the patient lives. The other inhalants are such protein extracts as hairs, feathers, dust and molds. I also advise avoidance of known offending foods.

Treatment has to be individualized for the child in question rather than for the disease or disorder the child has.

220 Lakeview Avenue.

ABSTRACTS OF MEDICAL ARTICLES

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 1018, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

The Journal of the American Medical Association is limiting its Current Medical Literature section. Thus, our main source of information on articles written by our members has been greatly curtailed.

Initial Progress in Acute Myocardial Infarction. By Martin S. Belle, M.D., Morton M. Halpern, M.D., and Louis Lemberg, M.D. South. M. J. 47:334-338 (April) 1954.

This study of 107 cases of acute myocardial infarction, 81 in men and 26 in women, was undertaken to determine how soon in the course of an attack the prognosis could be estimated with a satisfactory degree of accuracy, and to evaluate the factors which differentiate a "good risk" from a "poor risk" case, as classified on an immediate, a 24 hour and a 48 hour basis. An attempt was made to determine whether differentiation into these two categories would enable one selectively to use Dicumarol in the "poor risk" group.

In 29 per cent of the cases there was a change in prognostic category within the first 48 hours, the highest mortality also occurring within that period. The authors listed as poor prognostic signs a history of heart failure or myocardial infarction and the appearance of severe shock, pulmonary edema or significant arrhythmia, but in the absence of these signs regarded the prognosis as favorable in a first attack of myocardial infarction, especially with no QRS changes. No deaths occurred in cases in which patients were admitted 24 hours after the onset of an attack, indicating perhaps an element of natural selection in that these patients as a whole were not so severely ill as the ones admitted immediately.

It is concluded that it is hazardous to differentiate a "poor risk" from a "satisfactory risk" case of acute myocardial infarction in the first 48 hours of the attack and that after that length of time, using the criteria enumerated, one may differentiate a "poor" from a "satisfactory" risk case with an adequate degree of accuracy.

A Cutaneous Test of Rheumatic Activity in Children. By Murray M. Streitfeld, Ph.D., and Milton S. Saslaw, M.D. Proc. Soc. Exper. Biol. & Med. 84:628-631, 1953.

In this study it is reported that inunction with an ointment containing 5 per cent tetrahydrofurfuryl ester of nicotinic acid (Trafuril) in 337 children caused localized cutaneous hyperemia and/or edema ("typical" reaction) in normal subjects and those with congenital heart disease or nonrheumatic conditions. Twenty of 22 patients with active rheumatic disease failed to show this typical hyperemia or edema. Their response ("atypical") consisted of either blanching, failure to react, or barely perceptible hyperemia. Inactive rheumatic patients and patients whose activity was suppressed by cortisone or aminopyrine gave typical reactions. The atypical response was observed in a few patients with tonsilitis or streptococcal sore throat, as well as rheumatic activity.

Caudal Anesthesia and Oil-Soluble Anesthesia in Anorectal Surgery; Resume of Results and Complications Encountered in 14 Years Experience. By Claude G. Mentzer, M.D. South. M. J. 47:455-459 (May) 1954.

The purpose of this paper is to report a satisfactory combination of anesthetic agents for the over-all welfare of the patient during and following anorectal surgery. This report is the result of a 14 year experience in which caudal propyl benzoate hydrochloride (Metycaine) was used in 3,443 cases for the operative anesthetic, and an oil-soluble anesthetic was used in 2,921 cases for the relief of postoperative pain.

Caudal Metycaine anesthesia in the series of 3,443 cases was shown to be 94.4 per cent efficient, thereby demonstrating the relative ease of its administration and showing its excellence as an anesthetic agent. Induction time of seven minutes was short. Complications were relatively few. In the chronic cardiac and other poor risk patients, however, it is recommended that an anesthesiologist should be in charge of the anesthesia if possible. For these patients an alternate method of anesthetic care is given as second choice. Precautions to prevent hazards should be taken in all cases.

The report of the 2,921 cases demonstrates that oil-soluble anesthesia is safe and that complications following its use are rare. Postoperative pain in this series was minimal, requiring an average of only one injection of narcotic per patient. Catheterization was done in 9.6 per cent of the cases; healing time averaged about 18 days; and the period of hospitalization was four days.

Traumatic Rupture of the Urinary Bladder. By James E. Kicklighter, M.D. South. M.J. 47:837-841 (Sept.) 1954.

In view of the increasing incidence of fractured pelvis with associated rupture of the urinary bladder, owing to the increasing number of automobile accidents, this article emphasizes the importance of recognition by all physicians of the presence of ruptured bladder and knowledge of correct treatment. Traumatic rupture of this organ is discussed, and the value of early diagnosis and treatment is stressed. Methods of diagnosis and treatment are presented, and also illustrations showing both the intraperitoneal and the extraperitoneal type of ruptured bladder.

Treatment of Aneurysms by Polythene Wrapping. By C. Frank Chunn, M.D. Ann. Surg. 139:751-762 (June) 1954.

The literature on Polythene wrapping of aneurysms is reviewed, and the etiology and symptoms of aneurysm are discussed. A series of 9 cases of aneurysm is reported in which Polythene wrapping was the treatment of choice. The aneurysm was in the thoracic aorta in 2 cases, in the abdominal aorta in 5 cases, in the common carotid artery in 1 case, and in the subclavian artery in 1 case. In type, the aneurysm was saccular in 2 cases and fusiform in 7 cases. The origin was arteriosclerotic in 8 cases and syphilitic in 1 case. The results were beneficial in 7 of the 9 cases.

Among the various methods suggested and employed to produce external compression of the vessel wall without causing rupture or to promote fibrosis and contraction of the lumen, Polythene wrapping seems to the author to be less traumatic and dangerous than the others. He concludes that this relatively simple method of coping with this difficult problem has proved to be sufficiently beneficial to encourage its use. Also, in his opinion early detection of the aneurysm and prompt employment of this therapy should effect improved results.

Death Following Phenylbutazone (Butazolidin) Therapy: Report of a Case. By David A. Nathan, M.D., F.A.C.P., Marvin L. Meitus, M.D., Lewis Capland, M.D., and Maurice Lev, M.D. Ann. Int. Med. 39:1096-1103 (Nov.) 1953.

Although used in the treatment of several thousand patients with a large percentage of favorable results from a therapeutic standpoint, phenylbutazone (Butazolidin) has produced various toxic manifestations in patients treated for arthritis and allied rheumatic disorders. The authors enumerate some 20 undesirable effects and 2 fatalities reported in the literature. They report a case in which the fatal outcome was due to an overwhelming toxic and possibly hypersensitivity reaction, manifested in the skin and viscera.

Sarcoma of the Uterus. By Gerald S. Williams, M.D. Am. J. Obst. & Gynec. 67:92-101 (Jan.) 1954.

The 15 cases of sarcoma of the uterus recorded at the Louisville General Hospital during the period 1927 through 1950 reprcsented 2 per cent of all uterine malignant disease observed there during that period. The relationship of sarcoma to carcinoma was 1 to 49. The review of this series here presented gives the incidence of sarcomatous change in myomas as 0.26 per cent. The symptoms are described as not specific, although pain, abnormal bleeding, and rapid enlargement of the uterus should suggest sarcoma. Surgical removal is regarded as the accepted treatment, radiotherapy being of doubtful benefit. The five year survival rate in this series was 15 per cent. In this uncommon but highly fatal disease, suggested means of increasing the cure rate are (a) early diagnosis by routine cytologic studies, (b) alertness to the possibility of sarcoma, both clinically and in the operating room, and (c) performance of total hysterectomy whenever hysterectomy is indicated for any reason.

Vesical Calculi Following Suprapubic Prostatectomy. By Benedict R. Harrow, M.D. Am. Surgeon 19:1184-1188 (Dec.) 1953.

A study of 360 patients subjected to suprapubic prostatectomy within a two year period disclosed that in 9, or 2.5 per cent, calculi developed postoperatively in the bladder. In 3 of the 9 postprostatectomy urethral obstruction developed, probably accounting for the stone formation. In the remaining 6 patients, however, no obstruction and no residual urine were present. In 5 of these 6 patients calculi with large protein centers developed. It was concluded that these protein centers represented slough, blood clot, or inflammatory debris retained in the bladder because of inadequate drainage. The use of thorough irrigation in order to remove these particles is suggested before the removal of the catheters. In addition, it is advised that all tabs of prostatic or bladder neck tissue be carefully trimmed away at the time of operation.

Calibrated Weber Test in Fenestration Surgery; Evaluation of Postoperative Serous Labyrinthitis. By J. Brown Farrior, M.D., Richard A. Bagby, M.D., and Cecil Thomas, B.Sc., M.D., B.Ch. A.M.A. Arch. Otolaryng. 58:81-93 (July) 1953.

Postoperative serous labyrinthitis is one of the great problems in fenestration surgery today. To reduce or eliminate postoperative serous labyrinthitis, there must be a calibrated method of measuring its type, degree, and duration. To obtain this goal, the authors have calibrated the Weber test, which now may be described as a new hearing test although it actually is only an audiometric adaptation of one of the oldest hearing tests. They have found it of value in determining the status and prognosis in recent cases of fenestration. In this article they report a study on the behavior of bone conduction in the recently fenestrated ear.

The postoperative course of bone conduction threshold is described as showing three phases: primary improvement, secondary depression, and tertiary improvement. The technic of the calibrated Weber test is described. With the Weber test, the sound may lateralize to the ear operated on from two different causes: (1) desirable physiologic improvement in threshold or (2) undesirable pathologic recruitment. The calibrated Weber test will differentiate lateralization to the ear operated on due to improved threshold from lateralization to the ear operated on due to recruitment. There is direct correlation between the secondary variations in the calibrated Weber test and the tertiary loss of high tones. A tertiary improvement in bone conduction threshold has been demonstrated by the calibrated Weber test. Current related studies are reviewed.

Knowledge of these findings will be of practical value in interpretation of the postoperative behavior of the fenestrated ear. It is hoped that the calibrated Weber test will prove of academic value in the detailed study of postoperative serous labyrinthitis. For its evaluation five criteria are proposed.

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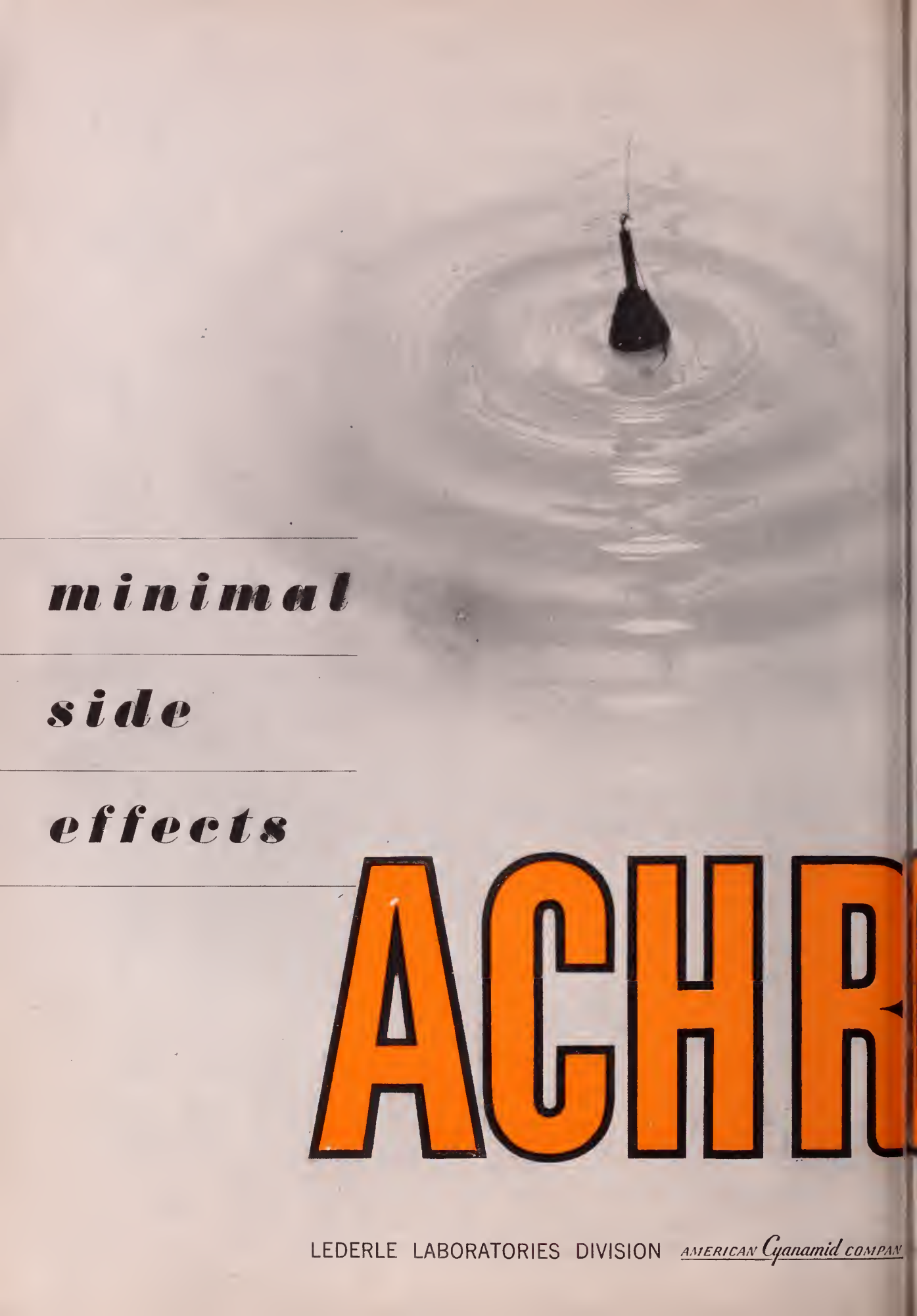
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"Watch Out" Watchword for 1955

The usual fanfare of watching the old year out and the new year in now is over for another year. As the first days of January 1955 are already keeping their date with history, the familiar expression "Watch out" lingers in the back of the mind. It well may have two sobering applications for the physician in the year just beginning. First, the phrase repeats itself sharply, as if in warning of the pitfalls that lie ahead. For example, there is the Bricker Amendment, which is of vital interest to the medical profession. Is it to be allowed to fall by the wayside again this year? Then there is the administration's reinsurance plan, sure to be resubmitted. The anomalous situation in the new Congress at best seems to be saying "Watch out." It invites alertness and unceasing vigilance on the part of American Medicine.

The second application has more pleasing implications. "Watch out" is the verbal prodding that serves as a reminder of the opportunities knocking on all sides. With New Year's resolutions still fresh in mind, the physician will do well to set the pattern for the year in constructive design. If he does not watch out, he may miss out on opportunities for community service and for participation in local social service projects. Professionally, if he does not watch out, he may miss some vital clue in a difficult case, overlook some key observation in research, or fail to recognize some important discovery or trend in clinical practice.

On the other hand, if he does watch out and makes a habit of doing so, he can make of 1955 a banner year. Just watching out a bit will bring greater professional attainment, stimulating contacts, relaxation that relaxes, broader contributions to the community life, coveted participation in the home life on a broader scale, shared interests with the children and, in fact, a thousand and one unexpected blessings. "Watch out" put into practice as the watchword for 1955 will pay surprising dividends. Why not adopt it and insure a progressive, constructive year?

The Malpractice Insurance Problem
II. How to Reverse Trend in Malpractice Insurance Rates

In last month's issue of The Journal the causes for increases in malpractice insurance rates were discussed editorially. In this issue a second editorial discusses measures to be taken to reverse the trend toward ever higher rates.

The bringing of a malpractice suit does not necessarily suggest that the suit has merit. Any patient treated by any physician may bring suit against him. More than half of the suits involve physicians who are above the average of their respective groups in skill, experience, and professional standing. What, then, can a physician do to protect himself and his professional reputation from unwarranted litigation? The answer to this question falls into three categories: those factors related to the physician, those related to the insurance companies, and those related to the medical association.

Of greatest importance are those factors related to the physician himself. These include not only what he should do but what he should *not* do. It is a significant fact that a large majority of malpractice claims arise out of a first course of treatment. It is rare for an old patient, one with whom a satisfactory doctor-patient relationship has been established, to institute suit for malpractice. The practicing of common courtesy in treating patients as people, in having some appreciation for their problems and regard for their sensibilities will go a long way toward establishing this desired relationship — and in minimizing the occurrence of malpractice suits. It might be termed applying the Golden Rule to the patient relationship. This is not only good for public relations, but it is money in the doctor's pocket in that his malpractice insurance rates are determined by the loss experience of the insurance companies.

This same old Golden Rule pays cash dividends when applied to relations with other doctors. In New York State, where the most complete and exact malpractice statistics in existence have been compiled, the precipitating causes of 500 cases of malpractice suits in 1952 were listed as follows:

1. Claim-minded patients urged to sue by friends or relations who were doctors, lawyers, or nurses, or who were themselves members of the profession — 37 per cent.
2. Doctors who sued to collect fees from dissatisfied patients — 23 per cent.
3. Callousness, failure on the part of the attending doctor to respond to the desires of the patients or to heed their complaints; resentment at the doctor's attitude of or lack of frankness; *neglect* — 20 per cent.
4. Unnecessary criticism by other doctors — 14 per cent.
5. Doctors' fees too high — 6 per cent.

It is likely that these statistics are fairly indicative of the situation as it exists in this regard in Florida. A perusal of these figures shows that 63 per cent of the 500 cases investigated were prompted by what might be termed unprofessional conduct on the part of the doctor. The loss in dollars and cents resulting from such suits is small when compared with the loss in prestige and in damaged public relations sustained by the *profession as a whole*. It is also obvious from examination of these statistics that if the members of the profession would like to have a 10 to 15 per cent reduction in their malpractice insurance rates, this can be accomplished by avoiding the unwarranted and unnecessary criticism of each other. Doing so does not mean that a doctor should keep silent in the face of obvious maltreatment and incompetence on the part of another physician; but it does mean that such matters can be handled in a better fashion than suggesting to the patient that he seek recourse in court.

What can be done to reverse the trend toward ever increasing rates for malpractice insurance? We can begin by cleaning house at home, and taking seriously our *personal* relations with patients as well as our public relations with the community. Putting grievance committees out of business for lack of complaints will be better malpractice insurance than money can buy.

In next month's Journal the role of the insurance company in malpractice insurance will be discussed.

EIGHTY-FIRST ANNUAL MEETING

FLORIDA MEDICAL ASSOCIATION

ST. PETERSBURG

APRIL 3-6, 1955

Preview of Health Legislation Outlook for 1955

Rep. Walter Judd of Minnesota, in an address before the Tennessee Valley Medical Assembly last fall, said: "Physicians must understand government and know their way in and out of it. In fact, they must become politicians in a measure." They must do so, he declared, because government is playing such a strong role in all phases of American life today. Dr. Judd was one of four out of five incumbent physician-members of the House of Representatives to win re-election. The others are Dr. Ivor D. Fenton, of Pennsylvania, and Dr. A. L. Miller, of Nebraska, both Republicans, as is Dr. Judd, and Dr. Thomas E. Morgan, of Pennsylvania, a Democrat. Dr. Will Neal, a West Virginia Republican, lost out in a bid for a second term to a former member of the Congress. Rear Admiral Ross T. McIntire, of California, personal physician to the late President Franklin D. Roosevelt and one time medical director of the American Red Cross, failed in his first bid for a Congressional seat. Dr. McIntire ran on the Democratic ticket and was defeated by the Republican incumbent.

Committee Chairmanships

Some committee realignments incident to the election results are of particular interest because of their bearing on medical and allied legislation. Chief among them are two key chairmanships, which will not go to the Democratic chairmen who became well known to the medical profession when the Democrats were in control before. Senator James E. Murray of Montana, a sponsor of national compulsory health insurance legislation, who was chairman of the Senate Labor and Welfare Committee in the Democratic 82nd Congress, again would be entitled to the post, but has decided instead to take the chairmanship of the Interior and Insular Affairs Committee. Senator Lister Hill of Alabama will preside over the Labor and Welfare Committee in the 84th Congress. This is the most important committee on health legislation. Senator Hill long has been interested in this legislation and was co-sponsor of the Hill-Burton hospital construction legislation passed in 1947. He is the son of a physician and has been in the Congress 30 years, 14 in the House before coming to the Senate.

In the House, J. Percy Priest of Tennessee moves up to chairmanship of the Interstate and Foreign Commerce Committee because former Democratic chairman Robert Crosser has retired from the Congress. This committee handles most medical legislation. Mr. Priest was the House majority whip in 1951-52 and for a time chairman of the Interstate and Foreign Commerce Committee's Health subcommittee. He is a former school teacher and newspaper man and has been in the House for seven uninterrupted terms. In recent years he has been extremely active in committee work in the health and medical fields.

Legislation - Reinsurance

For several months government departments have been busy polishing up legislation they expect to present to the 84th Congress this month. For example, the Civil Service Commission is working on plans for a United States employee health insurance program, the State Department wants a medical care plan for overseas personnel, the Defense Department is concerned with dependent care and medical scholarships, and the Department of Health, Education, and Welfare has a number of ideas, including a revival of reinsurance, possibly aid to medical schools, and, also only possibly, mortgage guarantees for health facilities.

Of paramount interest is the federal reinsurance program, defeated in the last Congress, which Secretary Oveta Culp Hobby continues to press. Early in the fall Mrs. Hobby told the American Life Convention that the administration is backing reinsurance because ". . . time is running against those who seek to keep health insurance on a voluntary basis." She added: "We still strongly believe in a bill . . . which seeks to compress the experimentation of the next 20 years into less than half the time through the simple mechanism of a broad sharing of risks. We believe such a bill will . . . nurture rather than weaken the voluntary health insurance concept."

Along with much of the insurance industry, the United States Chamber of Commerce and many other groups, the American Medical Association has opposed reinsurance as being unnecessary, as holding out false promises and as introducing the federal government into an area where it does not properly belong. Specifically, the AMA objects on these grounds: (1) the insurance carriers themselves have all the reinsurance money needed, (2) voluntary health insurance is making "extremely rapid" progress without reinsurance, (3) reinsurance would not make uninsurable risks insurable, and (4) without an objectionable subsidy reinsurance would not reduce the cost of insurance or "overcome the inertia of the unwilling

buyer." In view of this stand, it is particularly noteworthy that the AMA's Federal Liaison Committee has been conferring with Mrs. Hobby and officials of her department in an attempt to develop methods and procedures for effective liaison. The objective is to help promote the best interests of the American people in health and medical legislation through a continuing exchange of information and opinions between the AMA and the Department of Health, Education, and Welfare.

President Eisenhower has said repeatedly that he would introduce another reinsurance bill, possibly amended, and that may be expected, despite the fact that the Democrats helped to defeat the bill last session. In an address in New York City on Oct. 21, 1954, the President served notice that he would resubmit his reinsurance plan to the next Congress and promised that it would be "an important part of a health program in the great gaps in the field of health." He added that "we are years behind our potential achievement in the availability and adequacy of health services."

That same day, in one of her rare press conferences, Secretary Hobby said a task force of the Department of Health, Education, and Welfare would soon have a "clearer and better" bill to present to the President. Asked about AMA objections to the defeated reinsurance plan, Mrs. Hobby replied: "I very much hope that the AMA will see its way clear to support health reinsurance. We have the same objectives; the difference is only one of method." At this press conference the Secretary confirmed what was pretty well known. She explained that with the social security structure vastly expanded during 1954 and with federal action in educational fields waiting on the results of the coming White House conference, her department would concentrate its attention on health legislation in the 84th Congress. She remarked that social security coverage now is "almost as universal as it can be made."

Administration Objectives

Also late in October, the administration's objectives were summarized by Nelson Rockefeller, Under Secretary of the Department of Health, Education, and Welfare. Describing "our general approach to welfare," Mr. Rockefeller said: "This administration is irrevocably dedicated to promote the progressive expansion of the 'general welfare' as called for in the Constitution. It is inalterably opposed to the liberty-eroding concept of an ever-expanding 'welfare state.'" Dealing specifically with the medical issue, he declared that "we should never be content until every family in America can obtain the best of medical care, no matter how serious or how prolonged the sickness which strikes it." Commenting on the administration's reinsurance plan, in which "we still strongly believe," he invited suggestions: "We hope others will come forward with suggestions to improve the reinsurance concept the administration proposed, for we believe that we cannot afford to stand still where the health of the people of this nation is involved. The whole field of health is under intensive study in connection with the administration's legislative program for next year."

Next year is now this year, and the legislative wheels of the 84th Congress are beginning to grind. How this health program will fare under changed leadership in both the Senate and the House is, to say the least, problematic. Dr. Judd's advice to physicians to understand government and know their way in and out of it would seem to be peculiarly timely. For them to follow this advice might be to attempt the impossible, but they have attained the unattainable before.

Government Health Funds for Current Year

A survey[1] recently completed shows what each agency of the federal government will have to spend this fiscal year (July 1954 - June 1955) on health and medical programs. The figure exceeds the $2 billion mark, for the estimated total for federal health, medical and related activities is no less than $2,141,681,661. This sum is being spent for various projects which range from multi-million dollar hospitals to maintenance of clinics. The programs are spread among more than a score of departments, independent agencies and commissions.

To make this total more meaningful, it exceeds by 8 per cent the $1,775,882,000 budgeted by the federal government last year for the same purpose. This 8 per cent over-all increase, however, does not include the 70 per cent of the Defense medical budget increase that the department estimates is chargeable to operating and construction costs, items not available last year under the accounting procedure then in use. This sum is equivalent to 10 per cent of the $22,000,000,000 that represents the entire budget of the United States with defense security costs eliminated.

In addition, this year's total is approximately one-sixth of all the money spent in any way for medical and health items in this country annually,

including the cost of drugs, dental care, pharmaceutical items, and drug store sundries. The Department of Commerce estimates the total United States health bill at $12,000,000,000.

This survey covers every medical cost item that could be found in the federal budget or discovered through inquiries at the Bureau of the Budget and the individual agencies and departments. The Department of Defense of course receives the largest proportion of these funds—$845,487,500, or 39 per cent. The Veterans Administration follows with $748,738,563, or 35 per cent. The Department of Health, Education and Welfare is third with $395,754,000, or 18 per cent. None of the other 18 participating agencies receives more than 1 per cent of the remainder. The health funds the federal government is spending during the current fiscal year represent quite a sizable sum and an appreciable increase over the last fiscal year.

1. Special Report No. 23, Oct. 21, 1954, American Medical Association Washington office.

Nurses Now on Duty Number Four Hundred Thousand

Approximately 400,000 nurses now are on active duty in the United States. This figure represents an increase of 16,000 in five years. The estimate, taken from a recent Public Health Service survey, includes 231,000 hospital nurses, an increase of 15 per cent in four years. In addition, there are 74,000 private duty nurses, 35,200 nurses working in physicians' offices, 25,300 public health nurses; 14,000 industrial nurses; 8,200 nurse educators, and 1,900 in a variety of other fields.

The ratio of nursing personnel to patients today is at an all time peak, 74 per hundred. Nevertheless, Surgeon General Scheele stated that the need for nurses justifies the present annual student nurse recruitment goal of 55,000. This need reflects an increasingly health-conscious public expecting nursing care commensurate with the great progress of American Medicine.

American Medical Education Foundation

How interested are you in keeping American medical education free? Your medical school needs your financial assistance, and this is the month in which the 1955 fund-raising campaign gets under way. On January 23 the Fourth Annual Meeting of the American Medical Education Foundation state chairmen will be held at the Sheraton Hotel in Chicago. There discussions will be held and ideas will be exchanged with a view to prompt launching of the 1955 campaign for funds. Dr. Jack Q. Cleveland of Miami is state chairman for the Florida Medical Association.

In mid-November, the Foundation for the third consecutive year mailed a direct appeal for contributions to the subscribers to the Journal of the American Medical Association. Enclosed was a folder which pointed up income tax savings one may make by giving a contribution to the Foundation. Many members of the Association visited the Foundation's exhibit at the Eighth Clinical Session of the American Medical Association, held in Miami in late November and early December, where they were apprised of the latest facts and figures.

As of November 1 the Foundation's income had exceeded one million dollars during 1954. Since Jan. 1, 1954 the number of contributions received had reached 15,800, the total at that time amounting to $1,023,313, compared with 15,414 gifts totaling $960,859 during the same period in 1953. In the remaining eight weeks of the year efforts were made to reach a goal of $1,200,000 by December 31.

The supplement to the AMEF Annual Report for 1953 lists 46 Florida contributors to the Foundation, the sum contributed totaling $3,073. During 1953, the Foundation received 18,176 contributions amounting to $1,089,962. In addition, record is made of physicians who financially assisted medical education during that year by sending their donations directly to the medical schools. Florida physicians numbered 445, the amount contributed being $12,651. Complete figures indicate that 29,132 physicians contributed $1,369,137 directly to the nation's 79 approved medical schools during 1953. Florida doubtless has made a better showing in 1954, and as the movement gathers momentum, will do even better this year.

Animal Venoms Conference

The International Conference on Animal Venoms was held in Berkeley, Calif., late last month in conjunction with the annual meeting of the American Association for Advancement of Science. Comprising the program were some 60 papers presented by outstanding experts from all over the world. They covered the zoologic, chemical, pharmacologic and therapeutic aspects of this broad subject.

A key paper, entitled "Venom Research: A Challenge to the Various Sciences," was presented by C. B. Pollard, Ph.D., Professor of Chemistry at the University of Florida and Consulting Toxicologist to the Alachua General Hospital in Gainesville and the Morton Plant Hospital in Clearwater. Dr. Pollard is well known to Florida physicians for his research and has several times been a coauthor of articles published in The Journal.

In this paper, Dr. Pollard reviews his work on the toxicology of snake venoms, particularly of the crotalids. He also emphasizes the necessity for cooperation of effort in the fields of chemistry, biochemistry, physics, hematology, pathology, immunology, and medical therapeutics, especially serotherapy, for accumulation and evaluation of data on venoms.

Physicians of Florida should note that he particularly stresses the importance, to the researcher as well as to the clinician, of accurate and detailed case histories of patients hospitalized for treatment of envenomation. In addition, he reviews the evidence on the efficacy of Antivenin.

All of the contributions to the program of this conference will be published in due time.

New Orleans Graduate Medical Assembly

The eighteenth annual meeting of the New Orleans Graduate Medical Assembly will be held March 7-10, 1955, headquarters at the Municipal Auditorium.

Eighteen outstanding guest speakers will participate, and their presentations will be of interest to both specialists and general practitioners. The program will include fifty-four informative discussions on many topics of current medical interest, in addition to clinicopathologic conferences, symposia, medical motion pictures, scientific exhibits, round-table luncheons and technical exhibits.

The Assembly has planned another interesting postclinical tour to follow the 1955 meeting in New Orleans. On Saturday, March 12, a party composed of doctors and their families will leave New York for Europe via Pan American World Airways "President Special." The itinerary includes France, Italy, Germany, Denmark, Sweden and England, and arrangements have been made for medical programs in these countries. The tour ends in England, and the group will return to New York, sailing April 7 from Southampton on the "S. S. Liberte," or by Pan American World Airways.

Details of the New Orleans meeting and the postclinical tour are available at the office of the Assembly, Room 103, 1430 Tulane Ave., New Orleans 12.

Southern Medical Association Forty-Eighth Annual Meeting St. Louis, November 8-11, 1954

The St. Louis Medical Society was host to the Forty-Eighth Annual Meeting of the Southern Medical Association held in that city, Nov. 8-11, 1954. Many Florida physicians were present and took part in the activities of the meeting. There are more members of the Southern Medical Association from Florida and Texas than from any other states.

Members of the Florida Medical Association who presented scientific exhibits were: Drs. Carlos P. Lamar, Miami; James F. Lyons, Coral Gables; and Carl H. Davis, Miami.

Dr. Walter W. Sackett Jr. of Miami, chairman of the Section on General Practice, gave his chairman's address at a meeting of this group. Dr. James F. Lyons also spoke before a meeting of this section. At a joint meeting of the Sections on Medicine and on Pathology, Dr. George T. Harrell Jr. of Gainesville presented a paper. Dr. Gretchen V. Squires of Pensacola was secretary of the Section on Pathology.

Dr. Donald F. Marion of Miami spoke at a meeting of the Section on Gastroenterology. Dr. Marion and Dr. Marvin G. Flannery, also of Miami, took part in a panel discussion before this group.

Dr. J. Maxey Dell Jr. of Gainesville presented a paper before the Section on Radiology, of which Dr. Charles McC. Gray of Tampa was secretary. At the meeting of the Section on Dermatology and Syphilology Drs. Joseph A. J. Farrington of Jacksonville and Morris Waisman of Tampa were speakers.

Dr. James F. Lyons presented a paper before the Section on Industrial Medicine and Surgery. Dr. Philipp R. Rezek of Miami spoke before a meeting of the Section on Surgery. Dr. Donald W. Smith of Miami was secretary of this section.

At a meeting of the Section on Gynecology, Dr. Harold H. Ring of Chattahoochee was a speaker, and Dr. Richard C. Forman of Coral Gables spoke before a meeting of the Section on Obstetrics. Drs. Louis M. Orr and Miles W. Thomley of Orlando spoke before a meeting of the Section on Urology of which Dr. Milton M. Coplan of Miami was secretary.

Drs. Curtis D. Benton Jr. of Fort Lauderdale and Sherman B. Forbes of Tampa presented papers before the Section on Ophthalmology.

The Southern and Central Electroencephalographic Societies met conjointly with the Section on Neurology and Psychiatry. At this meeting Dr. Paul H. Jenkins of Daytona Beach presented a paper. Drs. Milton M. Coplan and Richard M. Fleming, both of Miami, spoke at a meeting of the Southern Society of Cancer Cytology which met conjointly with the Southern Medical Association.

The American Therapeutic Society also met in St. Louis at this time. Members of the Association who spoke at this meeting were Drs. Kenneth Phillips, Miami, and George T. Harrell Jr., Gainesville.

Registration

CHATTAHOOCHEE: Harold H. Ring. CORAL GABLES: Richard C. Forman, James F. Lyons. DAYTONA BEACH: Hugh Crawford, Paul H. Jenkins. FORT LAUDERDALE: Curtis D. Benton Jr., Roland F. Fisher, W. Dotson Wells. GAINESVILLE: Alva T. Cobb Jr., J. Maxie Dell Jr., George T. Harrell Jr. JACKSONVILLE: Joseph A. J. Farrington, Ivan Isaacs, F. Gordon King, Lauren M. Sompayrac, Edward C. Watt, Donald P. White Jr. KEY WEST: Wallace H. Mitchell. LAKE WORTH: Alva L. Rowe.

MIAMI: Reuben B. Chrisman Jr., Milton M. Coplan, Edward W. Cullipher, DeWitt C. Daughtry, Marvin G. Flannery, Richard M. Fleming, Forrest H. Foreman, Walter C. Jones, Carlos P. Lamar, Donald F. Marion, E. Sterling Nichol, Kenneth Phillips, Donald W. Smith, Joseph S. Stewart. OCALA: Robert E. Thompson. ORLANDO: Chas. J. Collins, John E. Crews, Byrne E. Taylor, Robert L. Tolle, Miles W. Thomley. PENSACOLA: Gretchen V. Squires, Raymond B. Squires. TAMPA: Chadbourne A. Andrews, Oliver F. Deen Jr., Sherman B. Forbes, Charles McC. Gray, Neal J. Phillips, Morris Waisman. WEST PALM BEACH: C. Jennings Derrick, Theodore Norley. WINTER PARK: Ruth S. Jewett.

Highlights of Miami A.M.A. Clinical Meeting

In Miami last November 29 at the opening session of the Eighth Clinical Meeting of the American Medical Association, President Walter B. Martin of Norfolk, Va., declared that "medicine belongs to the people" and physicians are "merely the purveyors" of medical care. Their obligation to the people, he added, "goes beyond our own private practice and into the community," and he stressed the importance of "continued effort to meet the medical needs of the low income and other noninsurable groups." Miami's Dinner Key Auditorium was the scene of this annual winter meeting, which was held for the first time in the Southeast. The four day meeting continued through December 2. Registration on the third day approximated 3,200 physicians, 3,500 guests including residents, interns, nurses and others, and 900 exhibitors and their guests, the grand total at that time exceeding 7,500. The Dade County Medical Association outdid itself in the role of host, and the Florida Medical Association was happy to join with this distinguished component society in welcoming and taking pride in having this great gathering in their midst.

Other speakers at the opening session were Mr. Seaborn P. Collins, National Commander of the American Legion, Mrs. Oveta Culp Hobby, Secretary of Health, Education, and Welfare, and Mr. Edwin J. Faulkner, President of the Woodmen Accident and Life Company of Lincoln, Neb. Remarking that "we are citizens first and doctors and veterans second," Mr. Collins urged removal of the veterans' medical care issue "from the area of name-calling and propaganda." The American Legion, he declared, neither expects nor wants the government to give carte blanche entitlement to medical care to all veterans. He expressed willingness to appoint qualified Legion representatives on a committee to take part in joint Legion-A.M.A. study of veterans' hospitalization. Later, the Board of Trustees appointed a committee, consisting of Dr. Elmer Hess, Dr. David Allman and Florida's own Dr. Louis M. Orr, to meet with the Legion on the issue of veterans' medical care.

In presenting the case for the Eisenhower administration's health reinsurance proposal, Mrs. Hobby said: "The health reinsurance proposal represents what we believe to be a necessity. It offers opportunity for self help without subsidy." In the opinion of Mr. Faulkner, however, the reinsurance program "would be foredoomed to disap-

point its proponents." Voluntary health insurance, he declared, can bring satisfactory protection "to practically all of our people" without a federal reinsurance program.

Among the major subjects of discussion and action by the House of Delegates were geriatrics, medical ethics, internships, grievance committees, hospital accreditation, osteopathy, the doctor draft law, state-subsidized medicine, and malpractice insurance problems. A new geriatrics unit was established with a view to improving and advancing the medical care rendered to people of the older age group. The Principles of Medical Ethics were amended with regard to patents and copyrights. The report of the Ad Hoc Committee on Internships was referred to the Council on Medical Education and Hospitals as a source of valuable guidance.

In order to improve efficiency and maintain high standards in the operation of grievance or mediation committees, the House asked the Board of Trustees to appoint a committee to study and report on recommended standards for the operation of such services. To resolve certain problems pertaining to hospital inspections, the Secretary of the American Medical Association was directed to request that the Joint Commission on the Accreditation of Hospitals supply a copy of the letter of notification regarding the results of the survey of each hospital to the hospital administrator, to the chief of the professional staff and to the chairman of the governing board of the hospital. Since studies on the osteopathic situation and on malpractice insurance were not complete, consideration of these matters was held in abeyance until the June 1955 meeting.

The House adopted a policy statement disapproving extension of the 'Doctor Draft Law' after June 30, 1955. It expressed confidence in the ability of the Board of Trustees and its Council on National Defense to handle properly any new situation which may develop in regard to this highly complex and involved problem, and urged them "to make recommendations to the Department of Defense at the earliest possible time for a more permanent solution to the problem, giving special attention to the further development of a career medical corps with adequate compensation therefor."

State-subsidized medicine proved to be the most controversial issue at the Miami meeting. A resolution on "Policy on Medical Practice by Tax Supported Medical Schools," introduced by the Mississippi State Medical Association, was referred, without approval or disapproval, to the Council on Medical Service, which is currently studying the various aspects of this subject.

The awarding of a citation to the American Medical Association for pioneering in helping to bring educational television to the American public was a feature of the closing session of the House of Delegates. James Keller, chairman of the Miami Citizens Committee for Educational Television, made the presentation on behalf of the National Citizens Committee for Educational Television, and President Martin accepted the award.

At the same session, the American Medical Education Foundation received from the Utah State Medical Society a check for $10,355 to aid in relieving the financial plight of the nation's medical schools. Dr. Louis H. Bauer, the foundation's president, received the contribution and announced that a check for $1,000 had been received from the Southern Medical Association.

An important announcement of the Board of Trustees concerned the appointment of a 13 member commission to make a comprehensive survey of the various types of plans through which the American people receive medical services. Dr. Leonard W. Larson of Bismarck, N. D., heads this commission, which will begin work at once and will require at least a year to complete its survey.

The honor of being the host city for the annual Clinical Meeting, which was Miami's in 1954, goes this year to Boston and next year to Seattle. Philadelphia was the choice for 1957, although invitations also were received from Denver, Detroit, Mexico City and Washington, D. C.

Registration

APALACHICOLA: Photis J. Nichols. APOPKA: Joseph L. Akerman. ARCADIA: Frank J. Liddy, Anthony D. Migliore. AVON PARK: Carl J. Larsen. BARTOW: Alfred S. Massam, John H. Miller, Chester H. Murphy, Janet B. Sutton. BAY PINES: Edward I. Melich. BELLE GLADE: Wilbert O. Norville. BRADENTON: Lowrie W. Blake, Roderic O. Jones, John S. Neill, Harvey C. Pauley Jr., Millard P. Quillian, Willett E. Wentzel. BRANFORD: Edward G. Haskell Jr. BUNNELL: John M. Canakaris. CLEARWATER: Raymond H. Center, Helen L. T. Dexter, Robert L. Neil.

COCOA: Thomas C. Kenaston. CORAL GABLES: John C. Ajac, A. Daniel Amerise, Raymond T. Anderson, Ira K. Brandt, Charles R. Burbacher, Henry H. Caffee, Philip J. Chastain, J. Kenneth Cole, Edward H. Cowell, Virginia L. Cowell, Anna A. Darrow, Franklin J. Evans, Richard C. Forman, George R. Gage, Glenn H. Heller, Frank W. Hewlett, Leonard I. Hodges, Charles F. Hudson, John A. Hughes, Jim S. Jewett, Harry D. L. Kaye, Robert P. Keiser, James F. Lyons, C. Howard McDevitt Jr., Burton T. Meadows, Jerome A. Megna, George A. Mitchell, Joseph R. Morrow, R. Sam Mosley, Wesley S. Nock, William S. Piper, Frederick P. Poppe, Warren W. Quillian,

Howard B. Russman, T. D. Sandberg, Irvin Seaman, Ben J. Sheppard, Eugene H. Silverstone, William P. Smith, Rollin D. Thompson, Martiele Turner, Karl W. Vetter, William L. Wagener Jr., A. Wm. Wallace, Arthur H. Weiland, Hillard W. Willis, Bernard Yesner. CRESCENT CITY: Bernard E. Kane.

CRYSTAL RIVER: William B. Moon. DANIA: Fred E. Brammer. DAYTONA BEACH: Fred H. Albee Jr., Hugh Crawford, Achille A. Monaco, L. Roland Young. DELRAY BEACH: Martin E. Buerk, Graham W. King Jr., James R. Nieder, Thomas Whitehead. EUSTIS: C. McK. Tyre. EVERGLADES: Edward J. Eckel. FERNANDINA BEACH: Cecil B. Brewton. FORT LAUDERDALE: Edward A. Abbey, Louis L. Amato, Miles J. Bielek, Julius F. Boettner, Oliver C. Brown, Russell B. Carson, Forest W. Cox, Alfred E. Cronkite, Frank Denniston, James W. Dickey Jr., Burns A. Dobbins Jr., George R. Dornberger, Frederick J. Driscoll, Robert L. Elliston, Richard L. Foster, Donald H. Gahagen, Walter J. Glenn Jr., Francis Haberman, George Hamerick Jr., Benjamin F. Hart, Rudolph W. Heath, Anne L. Hendricks, Garland M. Johnson, William H. Kirkley, M. Austin Lovejoy, Lloyd U. Lumpkin, Richard A. Mills, Robert U. Moersch, Claus A. Peterson, George T. F. Rahilly, Vincent V. Smith, Curtis H. Sory, Charles L. Wadsworth, LaVere G. White, Scottie J. Wilson.

FORT MYERS: James L. Bradley, Harry Fagan Jr., William H. Grace, H. Quillian Jones. FORT PIERCE: Alfred J. Cornille, Hugh B. Goodwin Jr., Richard F. Sinnott. FRUITLAND PARK: John B. Seeds. GAINESVILLE: Henry J. Babers Jr., James M. McClamroch. GULFPORT: James M. Neill. HALLANDALE: Maxwell M. Hartman. HIALEAH: James W. Andrews, Van M. Browne, Leon S. Eisenman, Eli Galitz, William C. Hutchison, Elizabeth K. Lovejoy, Albert W. McCorkle, Stanley J. Ruzow, Charles L. Shalloway.

HOLLYWOOD: Dale T. Anstine, Alexander H. Bluestone, Arthur Brill, Manuel G. Carmona, Bertram J. Frankel, Anthony C. Galluccio, Robert R. Harriss, John R. Hege Jr., Royle B. Klinkenberg, Louis J. Novak, Jacob A. Rosof, Bernard B. Seltzer, Ernest E. Serrano, Herbert J. Simon, Randall W. Snow. HOMESTEAD: Joseph H. Shain. JACKSONVILLE: Risden T. Allen, Sullivan G. Bedell, James L. Borland, Edward Canipelli, Cornelia M. Carithers, Hugh A. Carithers, Joseph L. Chilli, Silas M. Copeland, Samuel M. Day, Lawrence E. Geeslin, Albert V. Hardy, Edward Jelks, Samuel R. Lamb, Thomas H. Lipscomb, Joseph J. Lowenthal, Charles F. McCrory, Matthew E. Morrow Jr., Seymour Morse, Lorenzo L. Parks, George I. Raybin, C. Burling Roesch, Clarence M. Sharp, Wilson T. Sowder, Walker Stamps, Sidney Storch, Samuel M. Wells, J. Frank Wilson.

KEY WEST: Edward Gonzalez, Ralph Herz, Herman K. Moore. LAKELAND: Jere W. Annis, James R. Boulware Jr., John E. Daughtrey, Louis J. Polskin, John W. Vaughn. LAKE WALES: Willard E. Manry Jr. LAKE WORTH: Leonard W. Appleby, Carl M. Pults, Arthur T. Rask, Alva L. Rowe, A Scott Turk. MARATHON: Elmer J. Eisenbarth. MELBOURNE: Oswald A. Holzer, Theodore J. Kaminski.

MIAMI: Lawrence Adler, Julius Alexander, Lassar Alexander, Ralph F. Allen, James L. Anderson, Lauren L. Andrews, Norman S. Angel, Edward R. Annis, Roger J. Arango, Samuel Aronovitz, William G. Aten, Harold P. Auslander, Hubert A. Barge, Ernest R. Barnett, Martin S. Belle, Harry E. Beller, Aaron Bernstein, Maurice Blinski, Abraham Bolker, William K. Boros, Robert J. Boucek, John C. Branham, Emanuel H. Bresler, David Brezin, Earlsworth C. Brunner, John E. Burch, Reuben N. Burch, O. Whitmore Burtner, James A. Campbell, Meredith F. Campbell, Bruce D. Carroll, Gerard F. Carter, Chester Cassel, Turner E. Cato, Silas E. Chambers, John G. Chesney, Reuben B. Chrisman Jr., Isaac B. Cippes, Marcus B. Cirlin, Richard C. Clay, Benjamin Coleman, George D. Conger, Francis N. Cooke, Maurice P. Cooper, Milton M. Coplan, Vincent P. Corso, Edward W. Cullipher, DeWitt C. Daughtry, David Davidson, Carl H. Davis, Harold E. Davis, Michael P. DeBoe, John E. Dees, Lydia A. DeVilbiss, John W. Dix, Percy L. Dodge, L. Washington Dowlen, Otto S. Dowlen, Adolph E. Drexel, John G. DuPuis.

Howard K. Edwards, Herbert Eichert, Lee W. Elgin, Wm. H. Ellis, Byron D. Epstein, Bruce M. Esplin, Raymond L. Evans, Frederick E. Farrer, Robert F. Farrington, Leon R. Feldman, George Ferré, Nicanor Ferrer, James E. Fischer, Willard L. Fitzgerald, Emmett T. Fitzpatrick, Marvin G. Flannery, Richard M. Fleming, M. Jay Flipse, Roger J. Forastiere, Forrest H. Foreman, Wm. H. Forthman, Sidney Fox, Tom R. Gammage, Hollis F. Garrard, Samuel Gertman, Aron N. Gillman, George Gittelson, Francis W. Glenn, Herman Glassman, Edwin F. Gouldman, J. Raymond Graves, Harrien W. Gray, James J. Griffitts, Leo Grossman, Etheridge J. Hall, Morton M. Halpern, Daniel O. Hammond, Morton L. Hammond, John V. Handwerker Jr., Fuad Hanna, Henry C. Hardin Jr., Robert M. Harris, Benedict R. Harrow, Maurice E. Heck, Ella M. Hediger, Francisco A. Hernandez, M. S. Hernandez, Blas C. Herrero, John R. Hilsenbeck, Bruce M. Hogg, Claude D. Holmes Jr., James W. Holmes, William M. Howdon, R. Spencer Howell, Jack Humphreys, James J. Hutson.

Emil M. Isberg, William H. Izlar, Ralph W. Jack, Truxton L. Jackson, Joseph T. Jana Jr., Paul S. Jarrett, Edwin J. Jensen, Edward G. Jeruss, Manuel E. Jimenez, James K. Johnson, Samuel H. Johnson, Walter C. Jones, Ferdinand H. Kauders, Jack J. Kaufman Jr., Christian Keedy, Jack Keefe 3rd, Theodore C. Keller, Paul Kells, Alexander I. Kernish, Daniel Kindler, Ralph E. Kirsch, David Kirsh, Erna K. Klass, Morris E. Kuckku, Alexander Kushner, George E. Lacy, Carlos P. Lamar, George W. Lawson, Frederick LeDrew, Robert M. Lee, Louis Lemberg, Lee W. Lerner, Alfred G. Levin, Nathaniel M. Levin, Morris J. Levine, George D. Lilly, Simon M. Lipton, George Lister, Wm. D. Lithgow, A. Buist Litterer, Joseph Lomax, Manuel C. Lores, Robert O. Lyell.

John J. McAndrew, Archie McCallister Jr., E. Norton McKenzie, Jack A. McKenzie, Wm. W. McKibben, Norman W. McLeod Jr., Robert A. McNaughton, James K. McShane Sr., James K. McShane Jr., Martin P. Mahrer, Plumer J. Manson, Stanley Margoshes, Donald F. Marion, Isidore Marx, John H. Mason, Lawrence R. Medoff, Matthias P. Meehan, Perry D. Melvin, James H. Mendel Sr., Claude G. Mentzer, Hyman Merlin, Allan K. Michaelson, Robert F. Mikell, John D. Milton, Leon H. Mims Jr., Harry M. Moore, C. Russell Morgan Jr., Albert H. Mouradian, Alfred J. Nadler, Norman Nash, S. Robert Nash, Leo L. Nastasi, Florence Nathanson, Elwin G. Neal, Jacob Neber, Samuel Neustein, E. Sterling Nichol, Frank O. Nichols, Donald H. Nixon, James J. Nugent, Russell K. Nuzum Jr., Benjamin G. Oren.

Samuel W. Page Jr., Raymond E. Parks, Mary C. Patras, Frazier J. Payton, Colquitt Pearson, Homer L. Pearson Jr., Nelson T. Pearson, Max Pepper, Maxine R. Perdue, Irwin Perlmutter, Roland F. Phillips, Robert C. Piper, Edwin P. Preston, James H. Putman, John R. Ramey, Harold Rand, Jack O. W. Rash, Homer A. Reese, Lawson S. Rentz, W. Carlton Rentz Jr., Maurice Rich, John R. Richardson, Julian A. Rickles, Samuel J. Roberts, George W. Robertson III, James G. Robertson, Reuben Rochkind, Hunter B. Rogers, Charles Rosenfeld, Manning J. Rosnick, Bernard D. Ross, John S. Rossi, Robert L. Roy, John K. Rozum, Frank G. Ruhl Jr., Ruth W. Rumsey, Lyle W. Russell, Thomas N. Ryon, Walter W. Sackett Jr., S. Marion Salley, Ralph S. Sappenfield, Milton S. Saslaw, Chaffee A. Scarborough, Oden A. Schaeffer, John M. Schultz, Joseph W. Scott, Harold M. Silberman, John T. Smedley, Donald W. Smith, Federico A. Smith, James H. Smith, Parke G. Smith, Harold W. Snodgrass, John W. Snyder, John A. Speropoulos, Robert T. Spicer, Donald G. Stannus, William Steinman, Irving Stemerman, A. Lester Stepner, Theodore R. Stevens, Franz H. Stewart, Joseph S. Stewart, Chauncey M. Stone Jr., Richard F. Stover, Richard E. Strain, Theodore R. Struhl.

Joseph E. Thomas, Kelly C. Thomas, James I. Thorne, Walter R. Tobin, Frank W. Trombly, John P. Turk Jr., Herbert W. Virgin Jr., Harrison A. Walker, Isaac N. Weinkle, Philip Weinstein, Robert C. Welsh, Kenneth S. Whitmer, William Wickman, Edward H. Williams, George

Williams Jr., Oliver P. Winslow Jr., Louis J. Wisch, Arthur W. Wood Jr., Frank M. Woods, Leo S. Wool, Jack L. Wright, Scheffel H. Wright, Corren P. Youmans, Iva C. Youmans, Paul A. Zimmerman, Leo A. Zuckerman.

MIAMI BEACH: Mortimer D. Abrashkin, Seymour L. Alterman, Bernhard Baer, Herman Boughton, Judd R. Breakstone, Raymond Breitbart, Elliott C. Cohen, Herman Cohen, Victor Dorf, Rudolph E. Drosd, Maurice I. Edelman, Howard A. Engle, David W. Exley, I. Leo Fishbein, Harold H. Fox, Elias Freidus, N. Stuart Gilbert, Lewis G. Glueckauf, Milton S. Goldman, Bernard Goodman, Max Gratz, Robert J. Grayson, Irvin M. Greene, Jesse O. Halpern, Abraham R. Hollender, Paul K. Jenkins, Valentine E. Jenkins, Lewis L. Julien, Saul H. Kaplan, Sherman R. Kaplan, Harold S. Kaufman, Bernard S. Kleinman, Samuel B. Kleinman, Mathew W. Kobak, Maurice Kovnat, Victor H. Kugel.

Wilfred Lansman, Andrew J. Leon, George N. Leonard, Maurice Lev, Leo M. Levin, Sanford Levine, Alexander Libow, Charles Lippow, Rose E. P. London, Seymour B. London, Joseph H. Lucinian, Irwin H. Makovsky, Leon H. Manheimer, Meyer B. Marks, Marvin L. Meitus, Morton B. Morgan, David A. Nathan, Harry Needelman, Cayetano Panettiere, Julius R. Pearson, Jean J. Perdue, Paul Plotkin, Benjamin G. Pollock, Francis A. Reed, Paul S. Roland, Maurice J. Rose, Herman G. Rosenbaum, Alexander E. Rosenberg, Edward Roth, Leonard G. Rowntree, Jack A. Rudolph, Stanley E. Schwartz, Sol E. Selevan, Randolph Shevach, Charles Stein, Guy R. Stoddard, S. Montague Stone, John H. Tanous, Earl R. Templeton, Efton J. Thomas, Nicholas A. Tierney, Rene A. Torrado, M. P. Travers, Leonard L. Weil, William S. Weinkle, S. Charles Werblow, Charles B. Wigderson, Melvin Wolkowsky, Daniel H. Zimmerman, Maurice Zimmerman, Nelson Zivitz.

MIAMI SHORES: Jesse C. McMillan, Robert A. Mayer, Carl M. Midkiff. MIAMI SPRINGS: Joseph C. Frell, Clyde T. Thompson. MOUNT DORA: Fred A. Vincenti. NAPLES: James A. Craig, Earl S. Davis, Ethel H. Trygstad, Reidar Trygstad. NORTH MIAMI: George F. Bicknell, Charles F. Biggane, Valentine Bloch, George R. McClary, Mario V. Scandiffio, Ludwig M. Ungaro, Charlotte K. Wilkins. NORTH MIAMI BEACH: Raymond W. Healy. OCEANWAY: William E. Lamb. ORLANDO: Benjamin L. Brock, Warren A. Brooks, Russell V. Douglas, Eugene L. Jewett, Harold W. Johnston, William H. Kelley, Lawrence H. Kingsbury, Solomon D. Klotz, Jackson W. Landham, Morton Levy, Duncan T. McEwan, James A. McLeod, Meredith Mallory, John G. Marsh, John P. Michaels, Pleasant L. Moon, Louis M. Orr, George P. Schanck Jr., Joseph G. Seltzer, Charles R. Sias, Philip F. Simensky, Joseph L. Stecher, Alfred S. Stevenson, W. Dean Steward, Sam N. Sulman, Leroy M. Sutter, Jack P. Ward.

ORMOND BEACH: B. Arthur Smith, Orin R. Yost. PAHOKEE: Ernest C. Johnson Jr. PALM BEACH: Fred E. Manulis, Walter G. Robinson, Herman G. Rose. PANAMA CITY: William C. Roberts, C. W. Shackelford. PASS-A-GRILLE: George O. Gundersen. PENSACOLA: Edward F. Aarons Jr., Herbert L. Bryans. POMPANO: George S. McClellan. POMPANO BEACH: Frank L. Mikes. PORT ST. JOE: Albert L. Ward. RIVIERA BEACH: Frank M. Hewson Jr., Robert Y. Wheelihan. ST. AUGUSTINE: S. Raymond Cafaro, James J. DeVito, Vernon A. Lockwood, Hardgrove S. Norris, J. J. Spencer, A. Clark Walkup.

ST. PETERSBURG: Arnold S. Anderson, Russell C. Bane, Elmer B. Campbell, Harry R. Cushman, Chas. L. Farrington, Rodes C. Garby, Clifford D. Hartman, Paul S. Herr, Douglas W. Hood, William E. Kendall, Robert M. Kilmark, Francis H. Langley, Irwin S. Leinbach, Whitman C. McConnell, James K. McCorkle, James H. McRae, Frank L. Price, John P. Rowell. SANFORD: Terry Bird, J. Clifford Boyce, Wade H. Garner. SARASOTA: John M. Butcher, George M. Coggan, Michael A. DiCosola, Cecil E. Miller, Melvin M. Simmons. SEBRING: Leldon W. Martin. SOUTH MIAMI: Henry H. Bryant III, Robert V. Edwards, Charles D. Ettinger, James H. Mendel Jr., James A. Vaughn Jr., Phyllis P. Vaughn, Franklyn E. Verdon. STUART: John M. Gunsolus, Paul S. O'Brien. SURFSIDE: C. J. Galinvaux, Samuel N. Tippett. TALLAHASSEE: Russell L. Anderson, Laurie L. Dozier, George H. Garmany, Francis T. Holland, J. Elizabeth Jeffress. TAMPA: Frank S. Adamo, Richard A. Bagby, Robert J. Davis, Celestino G. Fernandez, Elsie M. Gilbert, H. Phillip Hampton, Douglas D. Martin, James N. Patterson, Roy F. Saxon Jr., Marshall E. Smith, Mason Trupp, J. Maxwell Williams Jr., Robert W. Withers. VENICE: Talmadge S. Thompson.

VERO BEACH: John P. Gifford, B. Bowman Guerin, Erasmus B. Hardee, Kip G. Kelso. WEST PALM BEACH: Willard F. Ande, James R. Anderson, Robert V. Artola, Clarence L. Brumback, W. Wellington George, Richard S. Gill, Frederick K. Herpel, W. Ambrose McGee, David W. Martin, Walter R. Newbern, Theodore Norley, Ralph M. Overstreet Jr., Cecil M. Peek, James E. Robinson Jr., Raymond S. Roy, James R. Sory, James C. White. WINTER GARDEN: John J. Scanlon. WINTER PARK: Ruth S. Jewett, Walter B. Johnston.

Graduate Medical Education

The three day course in Hematology given at the George Washington Hotel in Jacksonville on Nov. 18-20, 1954, was presented by the Department of Medicine of the Graduate School of the University of Florida in cooperation with the Florida Medical Association and the State Board of Health. The total attendance was 71. This Seminar was highly specialized, presenting the most recent knowledge on hematology as well as laboratory technic in this field. Dr. William Dameshek of Boston, who is internationally known in the field of hematology, arranged the program. He was assisted in its presentation by Dr. Z. D. Komninos of Boston, Dr. James N. Patterson of Tampa, and Dr. John B. Ross of Jacksonville.

Details of the two day Seminar on Cardiovascular Diseases to be offered Feb. 17-18, 1955, are in the process of preparation. Among the instructors who have accepted a place on the program are Dr. George T. Harrell Jr., Dean and Professor of Medicine of the College of Medicine of the University of Florida; Dr. Henry T. Bahnson, The Johns Hopkins Hospital, Baltimore, and Dr. James W. Culbertson, Director, Cardiovascular Research Laboratories, State University of Iowa University Hospitals, Iowa City.

The time has been set for the twenty-third annual Short Course for doctors of medicine. This course will be given at the George Washington Hotel in Jacksonville on June 20-24, 1955. Among the faculty who have already accepted are Dr. Wilburt C. Davison, Dean of Duke University School of Medicine, Durham, N. C., and Dr. Hans Lowenbach, Professor of Psychiatry, Duke University School of Medicine, who will return to give the lectures on psychiatry.

OTHERS ARE SAYING

A Medical School Graduation Address Never Delivered

Last June, several thousand young medics received their diplomas after listening to graduation exercise addresses. These usually vary from the long-winded to the short-and-sweet, and from the boresome recitation of *cliches* to the succinct and stimulating. Such excerpts as we have read from the current crop ran the gamut of the aforementioned.

We wonder sometimes why these orators do not tell these kids the whole truth. It's true, a young physician should have the ideals and precepts of honesty, integrity, scientific zeal, and all the other utopic, hippocratic attributes held up before him in glowing, even baroque, fashion. We would not for one minute deny these esteemed gentlemen this oratorical or histrionic type of presentation, when called upon to make graduation addresses — it is their big moment, and it should be an equally big moment for enforced listeners.

And yet, there is such a paucity in these speeches of a few cardinal facts of life for young physicians. Why doesn't some great man, in addressing a medical school graduating class, tell them the one or two words which mean more to patients, literally, than all the factors which the orators emphasize, reemphasize and overemphasize?

Every patient wants an honest doctor, although it sometimes takes months or years for a community to find a physician is dishonest. Every patient wants a practitioner of impeccable integrity, yet, a reputation of integrity may be blasted suddenly in a community after years spent in building it. Every patient wants a thorough, scientific zealot for a personal physician, and is offended many times with "brush-off, production-line" methods. Yet these points in a graduation address could quite well be handled with mimeographed handouts.

But, of what possible benefit to the patient are these attributes, even to a superlative degree, if the patient can't obtain a physician at all, or, when needed? All the scientific skill, all the honesty, all the integrity, all the everything, hallowed and sublimated by the graduation orator, are as nothing to the patient as the two qualities, *dependability and availablity.*

These are the two qualities, little-advertised, little-exploited by the orators, but of these is the secret essence of a completely successful practice; these kids should be told!

Vincent T. Williams, M.D.

—*Missouri Medicine, September 1954*

Why a Medical Society

"No class of men needs friction so much as physicians; no class gets less. The daily round of a busy practitioner tends to develop an egoism of a most intense kind, to which there is no antidote. The few set-backs are forgotten, the mistakes are often buried, and 10 years of successful work tend to make a man touchy, dogmatic, intolerant of correction, and abominably self-centered. To this mental attitude the medical society is the best corrective, and a man misses a good part of his education who does not get knocked about a bit by his colleagues in discussions and criticisms.

The very marrow and fitness of books may not suffice to save a man from becoming a poor, mean-spirited devil, without a spark of fine professional feeling, and without a thought above the sordid issues of the day.

"The promotion and dissemination of medical knowledge throughout the state remains our important function. Physicians as a rule have less appreciation of the value of organization than the members of other professions. In large cities weakness results from the breaking into cliques

and coteries, the interests of which take precedence over others of wider and more public character. Jealousies and misunderstandings are not unknown, and there is a baneful individualism — every man for himself — a centrifugalizing influence against which the society is and has been the only enduring protest.

"The man who knows it all and gets nothing from the society reminds one of that little dried-up miniature of humanity, the prematurely senile infant, whose tabetic marasmus has added old age to infancy. Why should he go to the society and hear Dr. Jones on the gastric relations of neurasthenia when he can get it so much better out of the works of Einhorn or Ewald? He is weary of seeing appendices, and there are no new pelvic viscera for demonstration. It is a waste of time, he says, and he feels better at home, and perhaps that is the best place for a man who has reached this stage of intellectual stagnation."

Counsels and Ideals from the Writings of William Osler — Bulletin of the Los Angeles Medical Association, October 21, 1954

Times Change — Or Do They?

One often hears the expression, "My, how times change," but after glancing through a recent issue of the Illinois State Medical Society's News-Letter I wonder if times change as much as we sometimes are led to believe.

Someway, somehow, Dr. Harold Camp, secretary of the Illinois society, came up with this quote from Dr. Robert Boal of Peoria, which was published in 1882:

"The amenities of professional intercourse, and the obligations of medical men toward each other and the public, were perhaps better observed in 1850 than now. Then the doctor, next to the minister, was the trusted friend and counselor of every family to whom he ministered. He shared their joys, soothed their sorrows, and every passing year added to and cemented the attachment and affection between them. Now the doctor is regarded more in the light of a tradesman or mechanic, and is employed from the same consideration that a grocer, tailor or shoemaker is. The strong ties of gratitude and affection have almost ceased to exist. Relationship is now placed upon a mere commercial basis, and for this the profession is more to blame than the public."

—A.M.A. Secretary's Letter, October 5, 1954

DEATHS

Deaths — Non-Members

Middlebrooks, William E., Panama City. July 2, 1954
Kennedy, Wm. C., Florence, Ala. Aug. 26, 1954

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Andrews, James W., Hialeah
Balg, Joseph, Miami Beach
Beeson, James D., Jacksonville
Boucek, Robert J., North Miami Beach
Branham, John C., Miami
Brashear, Billy, Gainesville
Burke, Charles H., Jacksonville
Cohen, Herman, Miami Beach
Dexter, Helen L. T., Clearwater
Feaster, B. Lynn Jr., St. Petersburg
Fechtel, Albert T., Jacksonville
Gilliland, Charles H., Gainesville
Goss, Albert S. Jr., Jacksonville
Grunthal, Leonard H. Jr., Jacksonville
Hagel, Donald R., Jacksonville
Harrell, George T. Jr., Gainesville
Kelly, Walter C., Jacksonville
Lane, John G. Jr., Jacksonville
Lichtblau, Philip O., West Palm Beach
McCain, James R., Jacksonville
McClary, George R., North Miami
Page, George E., St. Petersburg
Perry, Benjamin F. Jr., Leesburg
Richmond, H. John, Lake Worth
Root, Samuel W., Jacksonville
Rozum, John K., Miami
Seaman, Irvin, Coral Gables
Shashy, Robert A., Jacksonville
Skyer, Roslyn, West Palm Beach
Snodgrass, Harold W., Miami
Stephens, John A., Jacksonville
Stone, Chauncey M. Jr., Miami
Sullivan, Edward J. Jr., Jacksonville
Vihlen, Frederick E., Homestead

STATE NEWS ITEMS

The Florida Association of Neurology and Psychiatry held its fall meeting in Wakulla Springs, November 13 and 14, with approximately 18 members in attendance. Dr. Robert H. Mickler of Tallahassee reported on the clinical aspects of the polio epidemic in Leon County. Mr. William Frates of Miami, president of the Florida Mental Health Association, presented the program of legislation in the field of mental health.

The 1955 Alumni Postgraduate Convention sponsored by the Alumni Association of the School of Medicine of the College of Medical Evangelists will be held in Los Angeles, February 15-17, according to Dr. William F. Quinn, general chairman of the convention's governing board. Outstanding lectures, panel discussions, and luncheon panel meetings, along with refresher courses, scientific and technical exhibits, and women's activities will be featured. The convention is geared primarily to the needs of general practitioners. The convention will be preceded by two days of refresher courses on the College's Los Angeles campus at the White Memorial Hospital. For further details write Walter B. Crawford, Managing Director, 316 North Bailey St., Los Angeles 33.

The National Eclectic Medical Association will hold its One Hundred and Seventh Annual Meeting in Miami Beach, May 17-19, 1955. The meeting will be held at the Sans Souci Hotel. Dr. J. Dillard Workman of Live Oak is president of the association.

The Seventh Annual Meeting of the American Academy of Forensic Sciences will be held in the Biltmore Hotel, Los Angeles, Feb. 17-19, 1955. The programs of the Academy meetings are geared to stimulate interest in medicolegal problems. For further information write Dr. W. J. R. Camp, University of Illinois College of Medicine, 1853 W. Polk St., Chicago, secretary, or Dr. Frederick D. Newbarr, 109 Hall of Justice, Los Angeles 12, Chairman of Local Committee on Arrangements.

Drs. Joseph J. Lowenthal and Irvin C. Schneider of Jacksonville attended a course in Recent Advances in Internal Medicine at the Pratt Diagnostic Clinic, Boston.

Dr. Anthony J. Barranco of Lake Wales has been appointed assistant surgeon for the Seaboard Airline Railroad.

Dr. John E. Burch of Miami represented the local cerebral palsy clinic at the Fifth Annual United Cerebral Palsy Convention in Washington, D. C., in November.

Drs. Lee H. Darby and Lawrence M. Hughes of New Smyrna Beach, and William W. Schildecker of Daytona Beach took part in a panel discussion on the public relations aspect of a drive such as the cancer fund drive, at the Eighth District Meeting of the Florida Division of the American Cancer Society in New Smyrna Beach on November 3.

Dr. Amsie H. Lisenby of Panama City has been reappointed to membership on the State Board of Medical Examiners by Acting Governor Charley E. Johns.

Drs. Joseph L. Selden Jr. and John S. Stewart of Fort Myers reported on the need of a tumor clinic for that city at the annual board meeting of the Lee County Chapter of the American Cancer Society recently. Officers named were Dr. Stewart, medical chairman; Dr. Selden, area director; and Dr. George D. Hopkins II, medical vice chairman.

Dr. Ira K. Brandt of Coral Gables spoke before the Gamma Epsilon Chapter of Beta Sigma Phi in November. His subject was nephrosis and what is being done by the Greater Miami Chapter of the National Nephrosis Foundation to combat this disease.

Dr. Robert E. Rothermel of St. Petersburg spoke on proposed changes in the health department fields for the state before the Clearwater Mental Health Association meeting on November 8. Dr. Rothermel is Pinellas County Health Director.

Dr. Mason Romaine III of Jacksonville addressed the Junior League of that city on December 7.

Dr. Edward R. Annis of Miami spoke to a luncheon meeting of the American Academy of Periodontology at the Empress Hotel, Miami Beach, in November. The meeting was held in connection with the meeting of the American Dental Association in that city.

Dr. George T. Harrell Jr. of Gainesville served as moderator of a panel for the American College of Cardiology held at the Third Interim Scientific Meeting of the college in Miami, November 11-13.

Dr. Joseph W. Eversole of Jacksonville spoke at a meeting of the Duval Medical Center Auxiliary on November 4. He discussed smoking and its relationship to cancer.

Dr. Robert F. Mikell of Miami addressed the Parents of the Blind, Inc., of South Florida on November 10. He spoke on early training of a blind child and medical progress in the prevention of retrolental fibroplasia.

Dr. Anthony C. Galluccio of Hollywood has been named representative director-at-large of the Broward County Tuberculosis and Health Association to the State Association Board. He succeeds Dr. Donald H. Gahagen of Fort Lauderdale who resigned recently.

Dr. Bruce M. Hogg of Miami spoke on the "Health Fair for the Public," at a meeting of the Dade Business and Professional Women's Club on November 3.

Dr. Alfred P. Seminario of St. Petersburg has returned to his practice after taking a postgraduate course in the treatment of fractures at the Massachusetts General Hospital, Boston. The course, sponsored by the Harvard Medical School, is held annually.

Drs. William W. Schildecker and George H. McSwain of Daytona Beach have returned from New York after taking a week's postgraduate studies on cancer at Memorial Hospital.

Drs. Richard P. Thompson and Rothwell C. Polk of Jacksonville attended the Southeastern States Cancer Seminar held in Miami recently.

Dr. Ludo von Meysenbug, formerly of Daytona Beach, has moved his practice to 216 New Haven Ave., Melbourne.

Dr. Raymond H. Center of Clearwater was recently paid tribute by the Clearwater Lions Club. November 9 was designated "Dr. Raymond H. Center Day" in honor of the doctor who served as governor of the International District there in 1949 and 1950.

Dr. Joseph A. Gibson of Bradenton spoke on the advancement in surgery from the days of the War Between the States to the present time at a recent meeting of the Judah P. Benjamin chapter, United Daughters of the Confederacy.

Dr. George T. F. Rahilly of Fort Lauderdale spoke on "Sewers for Health" at a meeting of the Fort Lauderdale Branch of the American Association of University Women in November.

Dr. S. Roy Higginbotham Jr. of Tampa has returned to his practice after attending a medical clinic in Baltimore in November.

Drs. Andrew J. Jesacher and Edward M. Langer of Sarasota attended the American College of Physicians Postgraduate Course at the College of Virginia, Richmond, on October 11.

Dr. Henry J. Vomacka of Sarasota has returned to his practice after attending the one-week course sponsored by the American Society of Anesthesiology in Cincinnati.

Dr. Joshua C. Dickinson of Tampa, President of the American Roentgen Ray Society, attended the fortieth annual meeting of the Radiological Society of North America, held in Los Angeles, Dec. 5-10, 1955.

Dr. Curtis D. Benton Jr. of Fort Lauderdale has been appointed instructor in ophthalmology for the 1955 meeting of the American Academy of Ophthalmology and Otolaryngology. He will teach a course in "Refraction: Handling the Difficult Patient."

Dr. Walter W. McCorkle, formerly of Daytona Beach, has moved his office to 1822 23rd Ave., Vero Beach.

The Florida State Board of Health announces that they have two free pamphlets available for distribution to practising physicians for use with diabetic patients. "When Your Doctor Says You Need Insulin" and "When Your Doctor Says You Should Test Your Urine" are simply written, clearly and profusely illustrated. These pamphlets may be obtained by writing to the Division of Health Information, Florida State Board of Health, Jacksonville.

The American Otorhinologic Society for Plastic Surgery announces its first Seminar in Plastic Surgery of the Head and Neck to take place in Miami Beach at the Sans Souci Hotel, Jan. 24-28, 1955.

Dr. James V. Freeman of Clearwater attended the Regional Meeting of the Federal Civil Defense Administration, Region 3, Thomasville, Ga., which was held in Atlanta, Ga., on December 15. He represented the Association in his capacity as chairman of the Committee on Emergency Medical Service.

The annual University of Florida Midwinter Seminar in Ophthalmology and Otolaryngology will be held again this year in Miami Beach. The dates are January 17 to 22, the lectures on Ophthalmology being scheduled for Monday, Tuesday and Wednesday, January 17, 18 and 19, and those on Otolaryngology for Thursday, Friday and Saturday, January 20, 21 and 22. As for several years past, the headquarters will be the Sans Souci Hotel.

The Florida Society of Ophthalmology and Otolaryngology will hold its annual midwinter convention at the Sans Souci Hotel in Miami Beach on Wednesday afternoon, January 19, 1954. The usual informal banquet will follow at 8 p.m. Registrants of the Midwinter Seminar in Ophthalmology and Otolaryngology, which meets concurrently, are privileged to attend.

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Marcus R. Caro, M.D., Chicago, Ill.
Dermatology
Joseph B. Kirsner, M.D., Chicago, Ill.
Gastroenterology
Willis E. Brown, M.D., Little Rock, Ark.
Gynecology
Tinsley R. Harrison, M.D., Birmingham, Ala.
Internal Medicine
Donald W. Seldin, M.D., Dallas, Tex.
Internal Medicine
William A. Sodeman, M.D., Columbia, Mo.
Internal Medicine
Leonard T. Furlow, M.D., St. Louis, Mo.
Neurosurgery
Thaddeus L. Montgomery, M.D., Philadelphia, Pa.
Obstetrics
F. Bruce Fralick, M.D., Ann Arbor, Mich.
Ophthalmology
George J. Garceau, M.D., Indianapolis, Ind.
Orthopedic Surgery
Jerome A. Hilger, M.D., St. Paul, Minn.
Otolaryngology
William Boyd, M.D., Toronto, Canada
Pathology
Louis K. Diamond, M.D., Boston, Mass.
Pediatrics
H. Dabney Kerr, M.D., Iowa City, Iowa
Radiology
B. Marden Black, M.D., Rochester, Minn.
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Secretary, Room 103, 1430 Tulane Avenue, New Orleans 12, La.

COMPONENT SOCIETY NOTES

Dade

The regular meeting of the Dade County Medical Association was held on December 7.

Duval

The Duval County Medical Society held its regular monthly meeting on December 7.

Manatee

The Manatee and Sarasota County Medical Societies held their Annual Seminar in Sarasota, December 4-10. This Seminar was originally introduced as a review for the busy practitioners of this area. The material presented this year was general in nature, but with the primary emphasis on geriatric problems. A panel from the Mayo Foundation conducted the Seminar.

Marion

The annual seafood supper of the Marion County Medical Society was held at the Magnolia Lodge on Nov. 16, 1954. A special guest was Dr. Duncan T. McEwan of Orlando, F.M.A. President.

Pinellas

Dr. J. M. Ingram Jr. of Tampa was guest speaker at the regular meeting of the Pinellas County Medical Society on December 6. His subject was "Occult Obstetrical Rupture of the Uterus."

Mr. Claude M. Andrews, State Director of Vocational Rehabilitation Service, spoke on the Service at the January 3 meeting of the Society.

Polk

The Polk County Medical Society held its regular meeting and a social hour and dinner in Winter Haven on November 10.

Sarasota

The Sarasota County Medical Society and the Manatee County Medical Society presented their Annual Seminar at the Orange Blossom Hotel in Sarasota in December. The Seminar was revived this year, not having been held for the past two years. The primary emphasis this year was on geriatric problems, and a panel from the Mayo Foundation conducted the Seminar. It was approved for credit for postgraduate study by the American Board of General Practice.

Volusia

Dr. Robert G. Neill of Orlando was guest of honor and principal speaker at the meeting of the Volusia County Medical Society on November 9. He described in detail the mechanism of the skull and brain injury and modern methods of treatment.

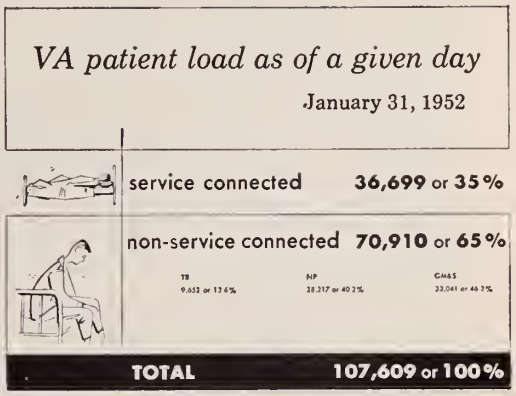
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In Viewing the VA Medical Program . . .



While the VA lists its patient load on a given day as 35% service-connected, only the long-range view of admissions and discharges over a year's time gives a truly accurate picture of the service-connected load (only 15.4%). This "discrepancy" appears because the VA's listing of 35% on a daily basis is not affected by the yearly turn-over of patients—the ratio of VA patients remaining to those treated and discharged (1 to 5.1). Over a period of a year, 84.6% of VA patients are treated for disabilities incurred after—and having no relationship to—military service.

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Dramamine's® Effect in Vertigo

Dramamine has become accepted in the control of a variety of clinical conditions characterized by vertigo and is recognized as a standard for the management of motion sickness.

Vertigo, according to Swartout, is primarily due* to a disturbance of those organs of the body that are responsible for body balance. When the posture of the head is changed, the gelatinous substance in the semi-circular canals begins to flow. This flow initiates neural impulses which are transmitted to the vestibular nuclei. From this point impulses are sent to different parts of the body to cause the symptom complex of vertigo.

Some impulses reach the eye muscles and cause nystagmus; some reach the cerebellum and skeletal muscles and righting of the head results; others activate the emetic center to result in nausea, while still others reach the cerebrum making the person aware of his disturbed equilibrium. *Vertigo may be caused by a disease or abnormal stimuli of any of these tissues involved in the transmission of the vertigo impulse, including the cerebellum and the end organs.*

A possible explanation of Dramamine's action is that it depresses the overstimulated labyrinthine structure of the inner ear. Depression, therefore, takes place at the point at which these impulses, causing vertigo, nausea and similar disturbances, originate. Some investigators have suggested that Dramamine may have an additional sedative effect on the central nervous system.

Repeated clinical studies have established Dramamine as valuable in the control of the symptoms of Ménière's syndrome, the nausea and vomiting of pregnancy, radiation sickness, hypertension vertigo, the vertigo of fenestration procedures, labyrinthitis and vestibular dysfunction associated with antibiotic therapy, as well as in motion sickness.

Any of these conditions in which Dramamine is effective may be classed as "disease or abnormal stimuli"* of the tissues including the end organs (gastrointestinal tract, eyes) and their nerve pathways to the labyrinth.

Dramamine (brand of dimenhydrinate) is supplied in tablets of 50 mg. and liquid (12.5 mg. in each 4 cc.). It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.



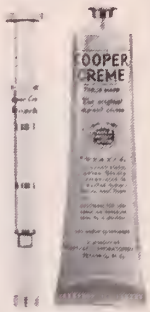
The site of Dramamine's action is probably in the labyrinthine structure.

*Swartout, R., III, and Gunther, K.: "Dizziness:" Vertigo and Syncope, GP *8*:35 (Nov.) 1953.



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Members Actively Supporting Auxiliary Projects

STUDENT LOAN FUND: Mrs. Ralph S. Sappenfield, Miami, reports that we have on hand for consideration several applications for loans of matching funds to our county auxiliaries with which to supplement their help to students needing assistance who desire to enter nurses training. We are hoping to accept these applications in the near future. Six years ago our state student loan fund was changed to include nurses training loans, and since that time we have helped many nurses to start and complete their training. Each year $200 is added to this fund from our budget which is made up of the dues paid the state Auxiliary by the members. Money is now being returned to us, and in the near future we hope to make this fund a revolving fund without further monies being added to it.

In evaluating the need for this project, we kept a close eye on the nurse recruitment exhibit of the A.M.A., F.M.A. and D.C.M.A. auxiliaries at the Health Fair for the Public, held in Miami from December 2 through December 5. The in-

quiries on nursing averaged about 200 per day for registered nurse information and about 100 per day for practical nursing courses. The last day (Sunday) we had about 450 inquiries on courses for registered nurses and about 150 for practical nursing courses. Many of those inquiring asked about the possibility of scholarship and loans. Experience and our belief in the ability of people to obtain education for themselves has led us to require our money be spent on loans rather than scholarships. Studies have shown that more nurses finish training when they have borrowed money than when they have been given it as scholarships.

Nurse Recruitment: Mrs. Augustine S. Weekley, Tampa, was in charge of a district meeting of the Future Nurses Clubs in District C in October — a most successful meeting with more than 100 high school students who are members of Future Nurses Clubs in this Medical District taking part. She is now in the process of planning for the state meeting of Future Nurses Clubs under the sponsorship of the state Auxiliary, this state meeting to be held March 18-19. The exhibit of the A.M.A. auxiliary on nurse recruitment has had its initial showing in Miami at the Health Fair for the Public and will be set up in Snow Hall at the Florida State Fair, February 5-19. New Future Nurses Clubs are springing up in high schools all over the state. The two newest reported to us are in Fort Lauderdale and Coral Gables. Reports from these clubs show that they serve a dual purpose — giving the high school student guidance for entrance into nurses school with an orientation as to what to expect when she enters, and, secondly, weeding out many students who have wanted to be nurses but who find out more about it and decide they don't want to enter training. This second purpose keeps our nurses training schools filled with girls who are more apt to finish their training, thus increasing the number of graduates. Mrs. S. James Beale, Jacksonville, as chairman of Public Relations, has been in charge of the project of renovating the living rooms at the Brewster Duval School of Nursing in Jacksonville. She is also in charge of our library project there — one of bringing the library of technical books up to the needs for permanent accreditation and filling in with novels and other literature for the nurses.

Mrs. Beale reports great progress in her work at Brewster. Furniture is being slip covered, drapes hung, end tables and lamps bought to make the living room a place of comfort. Technical books are being bought with the money sent in from various auxiliaries throughout the state. A 1902 novel was the latest in this library until the county auxiliaries started collecting books on travel, hobbies and good novels for the library.

The nurse recruitment project really has four main phases: Establishment of Future Nurses Clubs and encouragement of career-seeking women to go into nursing; establishment of as many accredited schools of nursing within the state as it is possible; maintenance of standards of schools so that they may remain accrediated; and encouragement of nurses to take postgraduate work in preparation for a good faculty for our accredited schools. The above also indicates that we have added matching funds to encourage our counties to give loans to worthy and needy students.

Public Relations: Through the generosity of the Florida Medical Association, a pamphlet encouraging the purchase of good voluntary health insurance has been developed for distribution particularly to women. Over 5,000 of these were passed out to people at the Health Fair for the Public in Miami; more will be used for the Florida State Fair in Tampa, the Citrus Exposition in Winter Haven and the Orange County Fair in Orlando. Distribution will also be made through members who will take them to their other organizations and pass them to the women there.

The need for such a pamphlet has been proven by the number of people who stopped at the Health Fair for the Public to talk over their insurance problems and to tell us of sad situations in which they had bought poor policies, not knowing what to look for in a policy. The pamphlet that has been developed does not advocate any certain company or type of insurance but points out the hazards in buying insurance and the need to purchase insurance to fit the need of the individual or family to be covered.

The activity of members in other of the Auxiliary projects will be discussed in future articles. Needles to say, all auxiliary members realize that their first objective is to serve the Medical Association of which they are the Auxiliary. All our projects are based on this service, and each serves medicine in one capacity or another.

Mrs. Richard F. Stover, President

OBITUARIES

Nonie Wilson Gable

Dr. Nonie Wilson Gable of St. Petersburg died at his home in that city on Oct. 9, 1954. He was 82 years of age.

Born in Brooks, Ga., on April 4, 1872, Dr. Gable was educated in his native state. He received the degree of Doctor of Medicine from the Atlanta Medical College, now the Emory University School of Medicine, where he was an honor graduate of the class of 1893. He then engaged in the general practice of medicine in Brooks and later in Griffin, Ga., until he came to St. Petersburg in 1923.

From 1929 until 1948, when the newly organized County Health Department took over his duties, Dr. Gable served as medical examiner for the city of St. Petersburg. Upon his retirement from active practice four years ago, he had completed 57 years in the practice of medicine; half of this period was spent in St. Petersburg. Locally, this veteran physician was a past president of the Lip Reading Club, and a member of the Lutheran Church and of Nitram Lodge No. 188, F&AM. A Knight Templar and Shriner, he was affiliated with the Coeur-de-Lion Commandry and the Yoorab Temple Shrine, both of Atlanta, Ga.

On Jan. 15, 1953, Dr. Gable was signally honored as a member of the Pinellas County Medical Society at a Medical Society and St. Petersburg Times Medical Forum, of which his son, Dr. N. Worth Gable, was an originator. Since 1929 Dr. Gable had been a member of the Florida Medical Association, holding honorary status since his retirement. He was also a member of the American Medical Association.

In 1894, Dr. Gable and Miss Hulette Malone were united in marriage. Mrs. Gable died in 1950. Surviving are three sons, Dr. N. Worth Gable, Dr. Linwood M. Gable, and Hulette R. Gable, all of St. Petersburg; a grandson, Roderick W. Gable, and two great grandchildren, Linda and Deborah Gable, all of Atlanta; and a sister, Mrs. James I. Woolsey, of Brooks.

(Continued on page 589)



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Diplococcus pneumoniae 44,000 X

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lobar and bronchopneumonia • chronic bronchitis • mastoiditis • sinusitis otitis media • and meningitis.

It is another of the more than 30 organisms susceptible to

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Hialeah	1210 Pacific Bldg.	Tampa	228 Cass Street Arcade Building
St. Petersburg	509 White Building	Sarasota	1369 Main Street, Room 15
Lakeland	206 Marble Arcade	Daytona Beach	116½ Orange Avenue
West Palm Beach	305 Citizens Building	Pensacola	501 Theisen Building

(Continued from page 586)

Louis Brown Bouchelle

Dr. Louis Brown Bouchelle of New Smyrna Beach died at his home on Sept. 5, 1954, after a long illness. He was 84 years of age.

The son of Louis B. and Sarah DeLoach Bouchelle, Dr. Bouchelle was born in Thomasville, Ga., on Sept. 17, 1869. He received his medical training at the Atlanta Medical College, now Emory University School of Medicine, and was awarded the degree of Doctor of Medicine by that institution in 1891. He then engaged in postgraduate work at McGill University in Montreal, Canada.

In 1894, Dr. Bouchelle came to Florida and engaged in the general practice of medicine in New Smyrna Beach. For many years he was physician for the Florida East Coast Railway and in a letter received after his death he received special commendation from Dr. V. A. Lockwood, that railroad's chief surgeon, for his valiant service to the community during the war years. Although he had retired from active medical practice prior to World War II, he resumed practice when younger physicians were no longer available. During World War I, he served as a lieutenant in the Army Medical Corps and afterward was active in organizing the American Legion and other patriotic groups in his home city.

At various times during the 60 years that he resided in New Smyrna Beach Dr. Bouchelle was active in the political, civic and business life of the community. This prominent physician was also a real estate broker and insurance agent. He served as a city councilman and county commissioner, founded two banks and operated a drug store.

Dr. Bouchelle had long been a member and was a past president of the Volusia County Medical Society. He became a member of the Florida Medical Association in 1902 and for 12 years had been a life member. He was also a member of the American Medical Association.

Surviving are the widow, Mrs. Anne Sams Bouchelle, a member of a pioneer family in that section of Florida; one daughter, Mrs. Paul Wimbish, of Miami Beach; one son, Anderson C. Bouchelle, of New Smyrna Beach, and many nephews and nieces. Another son, Louis B. Bouchelle Jr., died several years ago.

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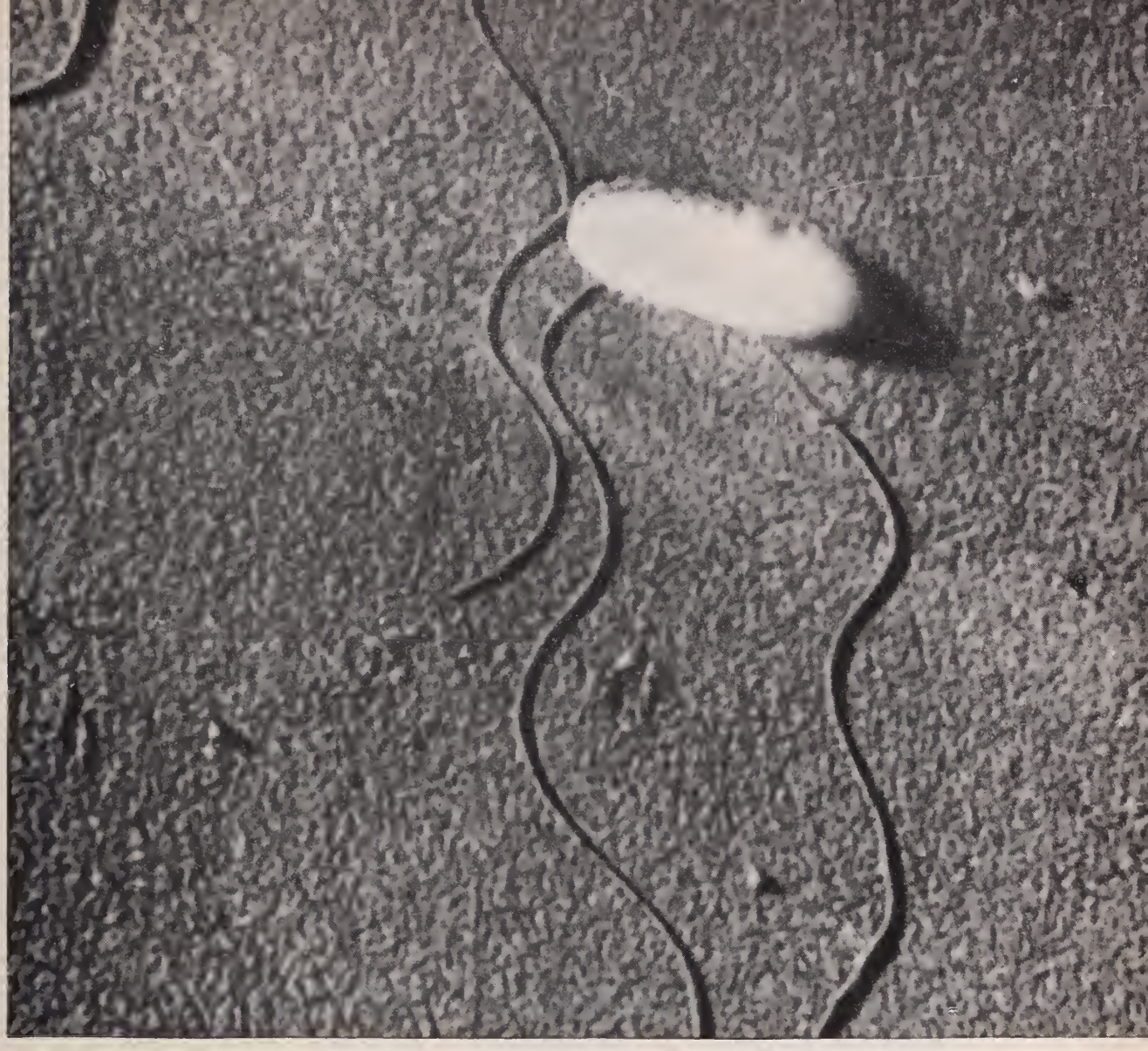
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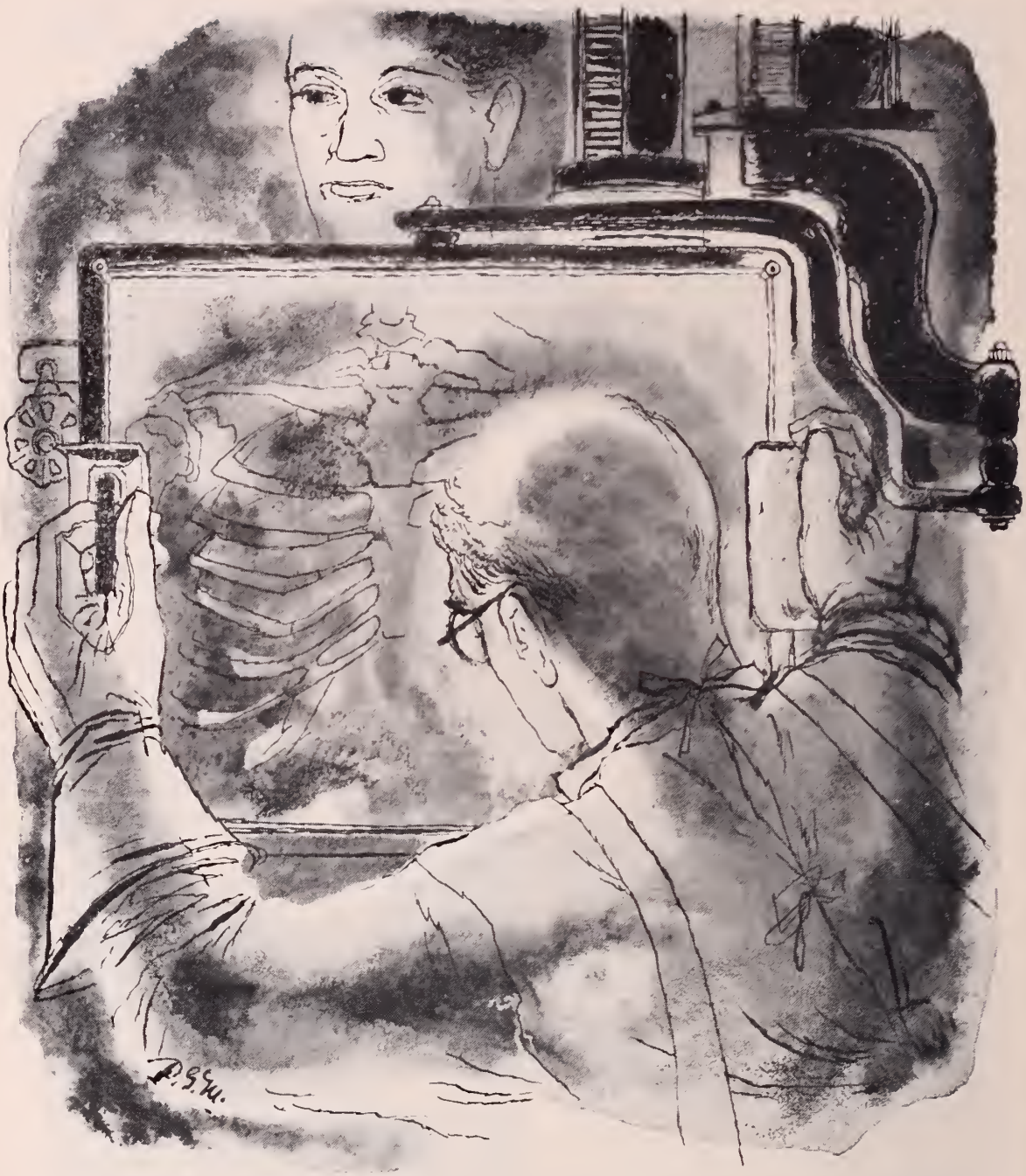
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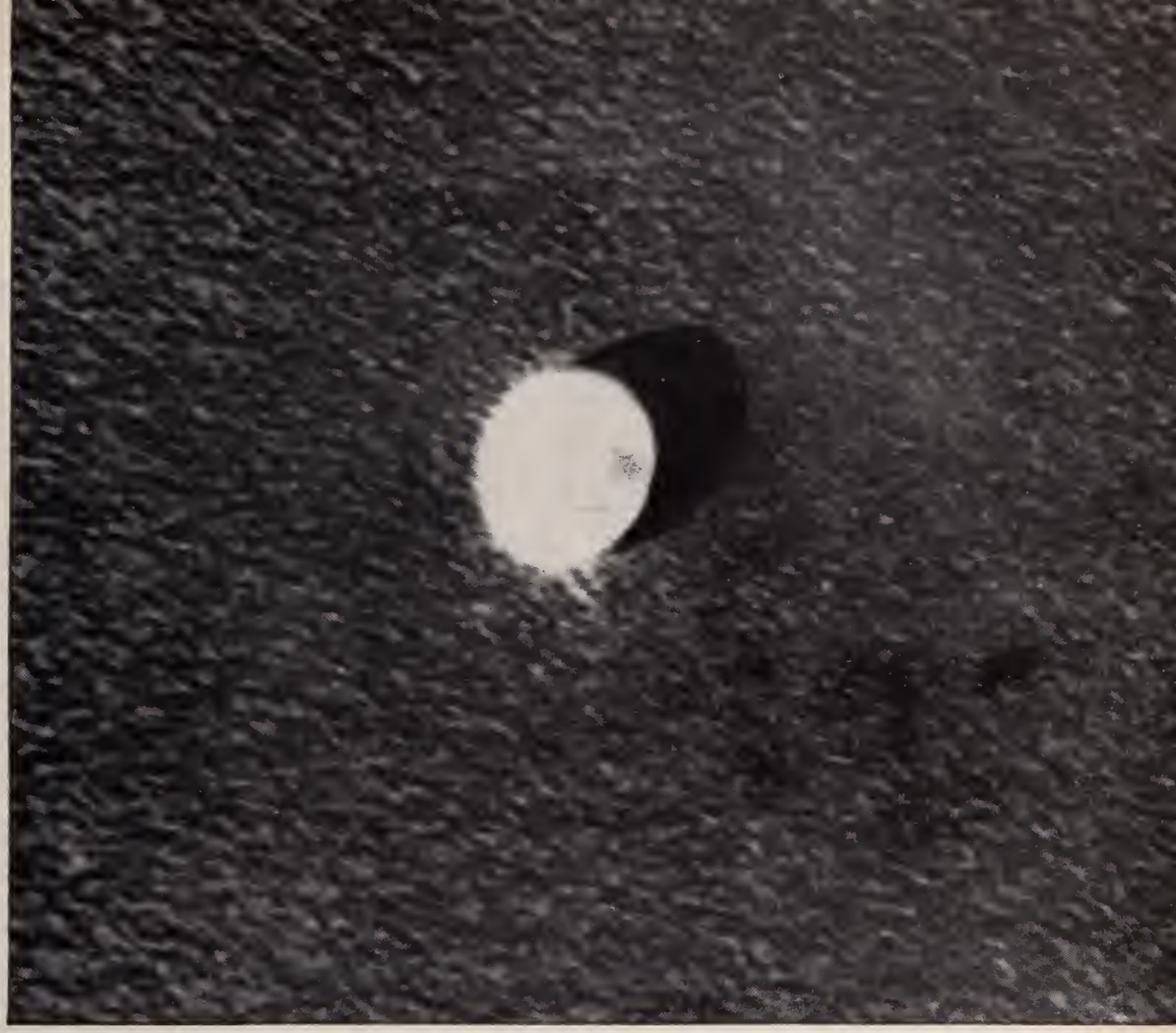
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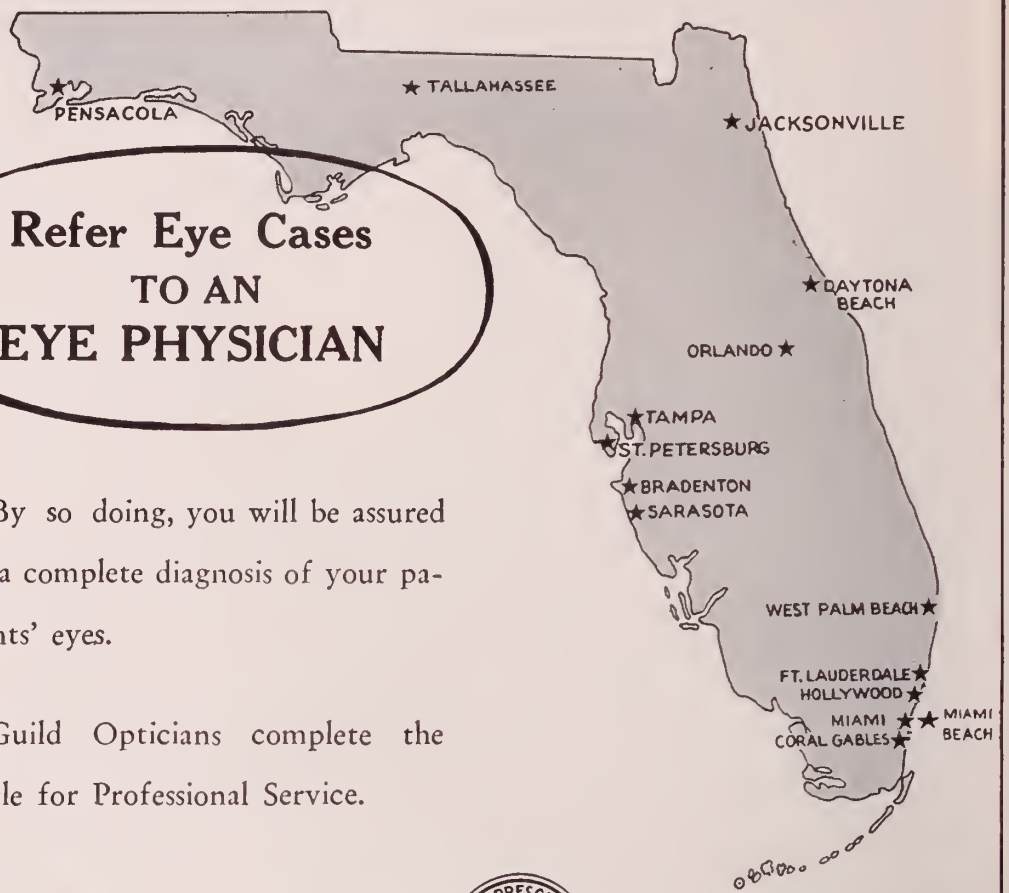
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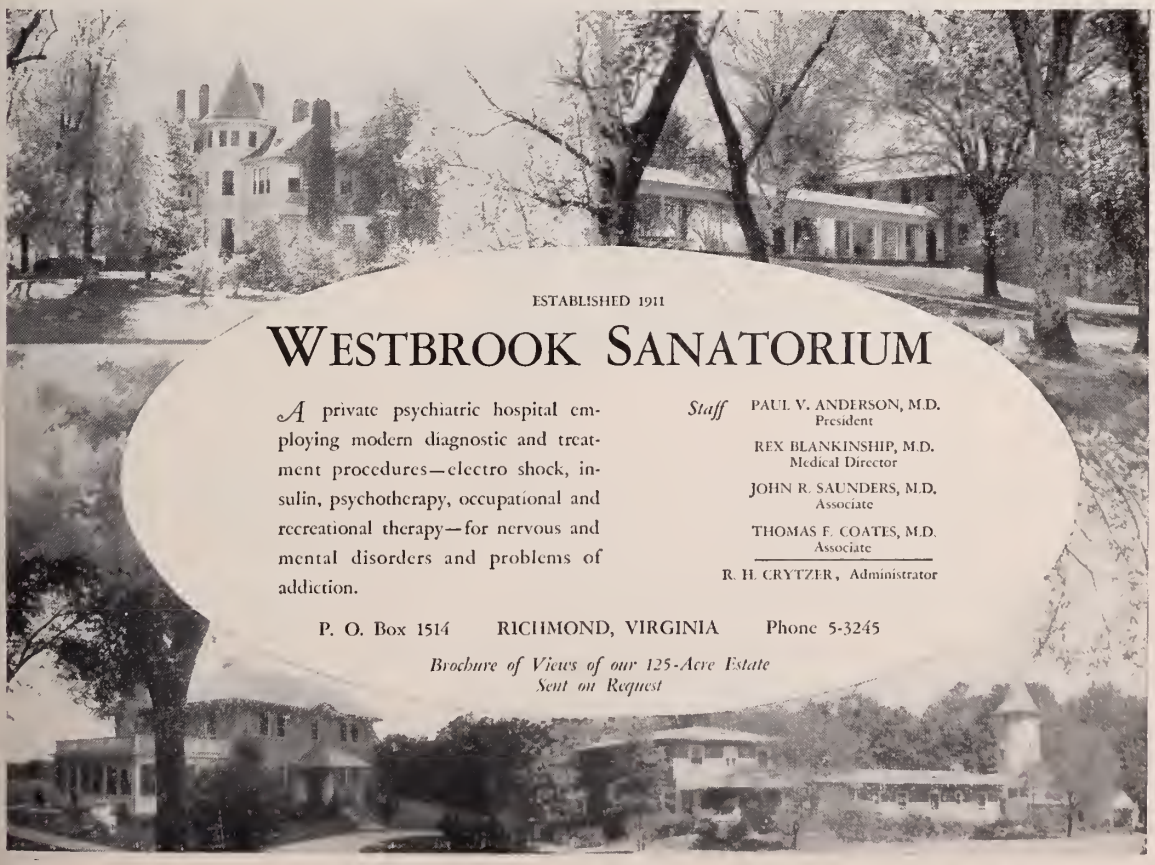
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
la Medical Association	Duncan T. McEwan, Orlando	Samuel M. Day, Jacksonville	St. Petersburg, Apr. 3-6, '55
la Medical Districts	Francis H. Langley, St. Petersburg	Council Chairman	
Northwest	William H. Hixon, Pensacola	George S. Palmer, Tallahassee	Pensacola
Northeast	Henry J. Babers Jr., Gainesville	Thomas C. Kenaston, Cocoa	Gainesville
Southwest	Clyde O. Anderson, St. Petersburg	James R. Boulware Jr., Lakeland	Lakeland
Southeast	James R. Sory, West Palm Beach	Russell B. Carson, Ft. Lauderdale	Fort Lauderdale
la Specialty Societies			
my of General Practice	Leonard L. Weil, Miami Beach	Leon S. Eisenman, Hialeah	St. Petersburg, Apr. 3, '55
ry Society	Solomon D. Klotz, Orlando	Edwin P. Preston, Miami	" "
hesiologists, Soc. of	R. Gaylord Lewis, West Palm Beach	Harry E. Bierley, West Palm Beach	" "
Phys., Am. Coll., Fla. Chap.	DeWitt C. Daughtry, Miami	Jack Reiss, Coral Gables	" "
. and Syph., Assn. of	Hollis F. Garrard, Miami	Joseph A. J. Farrington, Jacksonville	" "
h Officers' Society	Thomas E. Morgan, Jacksonville	Lorenzo L. Parks, Jacksonville	" "
trial and Railway Surgeons	Plumer J. Manson, Miami	John H. Mitchell, Jacksonville	" "
ology & Psychiatry	Sullivan G. Bedell, Jacksonville	Roger E. Phillips, Orlando	" "
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hal. & Otol., Soc. of	G. Tayloe Gwathmey, Orlando	Carl S. McLemore, Orlando	" "
pedic Society	John F. Lovejoy, Jacksonville	Newton C. McCollough, Orlando	" "
ologists, Society of	Millard B. White, Sarasota	James B. Leonard, Clearwater	" "
tric Society	Lewis T. Corum, Tampa	Joel V. McCall Jr., Daytona Beach	" "
ologic Society	Claude G. Mentzer, Miami	George Williams Jr., Miami	" "
logical Society	A. Judson Graves, Jacksonville	James T. Shelden, Lakeland	" "
ons, Am. Coll., Fla. Chapter	Frederick J. Waas, Jacksonville	C. Frank Chunn, Tampa	" "
gical Society	Linus W. Hewit, Tampa	Frank J. Pyle, Orlando	" "
da—			
sic Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, May 14, '55
od Banks, Association	John T. Stage, Jacksonville	John B. Ross, Jacksonville	St. Petersburg, 1955
ie Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	
ie Shield of Florida, Inc.	David R. Murphey Jr., Tampa	Jack O. W. Rash, Miami	
ncer Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	St. Petersburg, Apr. 3, '55
nical Diabetes Assn.	Sidney Davidson, Lake Worth	Edward R. Smith, Jacksonville	
ntal Society, State	Robt. Thoburn, D.D.S.,Daytona Bch	J. E. Edwards, D.D.S., Coral Gables	Jacksonville, Apr. 23-25, '55
art Association	Alvin E. Murphy, Palm Beach	Daniel R. Usdin, Jacksonville	April 1955
spital Association	Mr. J. F. Wymer Jr., W. Palm B.	Mrs. Mary Reeder, Miami	
dical Examining Board	Frank D. Gray, Orlando	Homer L. Pearson Jr., Miami	Jacksonville, June 20-25, '55
dical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
rse Anesthetists, Fla. Assn.	Miss Dorothy Jackson, C. Gables	Mrs. Lulla F. Bryan, Miami	
rses Association, State	Martha Wolfe, R.N., Coral Gables	Agnes Anderson, R.N., Orlando	
armaceutical Association, State	Mr. J. L. McDonald, St. Augustine	Mr. R. Q. Richards, Ft. Myers	Clearwater, May '55
blic Health Association	Mr. J. A. Mulrennan, Jacksonville	Mr. Fred B. Ragland, Jacksonville	
udeau Society	Lawrence C. Manni, Tallahassee	Simon D. Doff, Jacksonville	Miami, May 12-14, '55
berculosis & Health Assn.	Judge Ernest E. Mason, Pensacola	Mrs. W. J. Norton, Sarasota	Miami, May 12-14, '55
oman's Auxiliary	Mrs. Richard F. Stover, Miami	Mrs. S. J. Wilson, Ft. Lauderdale	St. Petersburg, Apr. 3. '55
rican Medical Association	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	Atlantic City, June 6-10, '55
M.A. Clinical Session	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	Boston, Nov. 29-Dec. 2, '55
hern Medical Association	Alphonse McMahon, St. Louis	Mr. C. P. Loranz, Birmingham	
ama Medical Association	J. M. Donald, Birmingham	Douglas L. Cannon, Montgomery	Montgomery, Apr. 21-23, '55
gia, Medical Assn. of	Peter B. Wright, Augusta	David Henry Poer, Atlanta	Augusta, May 1-4, '55
Hospital Conference	Mr. John W. Gill, Vicksburg, Miss.	Mr. Pat Groner, Pensacola	Atlanta, Apr. 20-22, '55
heastern Allergy Assn.	W. L. Rucks, Memphis, Tenn.	Kath. B. MacInnis, Columbia, S. C.	Orlando, 1955
heastern, Am. Urological Assn.	Sam L. Raines, Memphis, Tenn.	Robert F. Sharp, New Orleans	New Orleans Mar. 20-23, '55
heastern Surgical Congress	J. Duffy Hancock, Louisville, Ky.	B. T. Beasley, Atlanta	Atlanta, Mar. 7-10, '55
Coast Clinical Society	Walter C. Payne Sr., Pensacola	Barkley Beidleman, Pensacola	Pensacola, Oct. 27-28, 1955

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County Medical Societies of Florida

SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Total Members
Alachua	Henry H. Graham, Gainesville	Glenn O. Summerlin, Gainesville	2nd Tues.	56
***Bradford, Gilchrist, Union**				
Bay	Lemuel F. Coxe Jr., Panama City	James D. Nixon, Panama City	1st Tues.	26
Brevard	Theodore J. Kaminski, Melbourne	Isabel Roberts, Melbourne	2nd Tues	27
Broward	Julius F. Boettner, Fort Lauderdale	George T. F. Rahilly, Fort Lauderdale	4th Tues.	116
Columbia	Robert B. Harkness, Lake City	Thomas H. Bates, Lake City	1st Mon.	12
***Baker, Hamilton**				
Dade	Edward W. Cullipher, Miami	Kenneth S. Whitmer, Miami	1st Tues.	690
DeSoto-Hardee-Highland-Glades	Carl J. Larsen, Avon Park	Samuel A. King, Avon Park	1st Tues.	26
Duval	Karl B. Hanson, Jacksonville	Jackson L. Allgood Jr., Jacksonville	1st Tues.	287
***Clay**				
Escambia	Wilton E. Tugwell, Pensacola	Paul F. Baranco, Pensacola	2nd Tues.	105
***Santa Rosa**				
Franklin-Gulf	Albert L. Ward, Port St. Joe	Warren T. Weathington, Apalachicola	Last Wed.	8
Hillsborough	C. Frank Chunn, Tampa	Julien C. Pate Jr., Tampa	1st Tues.	180
Indian River	William L. Fitts 3rd, Vero Beach	Vernon L. Fromang, Vero Beach	2nd Tues.	10
Jackson-Calhoun	Jabe A. Breland, Marianna	Francis M. Watson, Marianna	Quarterly	17
Lake	Louis R. Bowen, Eustis	J. Basil Hall, Tavares	1st Wed.	30
***Sumter**				
Lee-Charlotte-Collier-Hendry	H. Quillian Jones, Fort Myers	James L. Bradley, Fort Myers	3rd Mon.	37
Leon-Gadsden-Liberty-Wakulla-Jefferson	George H. Massey, Quincy	Odis G. Kendrick Jr., Tallahassee	Quarterly	60
Madison	Wallace E. Winter, Madison	Julian M. DuRant, Madison		5
Manatee	Willett E. Wentzel, Bradenton	Marjorie L. Warner, Bradenton	2nd Tues.	25
Marion	William H. Anderson Jr., Ocala	Bertrand F. Drake, Dunnellon	3rd Tues.	30
***Levy**				
Monroe	Edward Gonzalez, Key West	Herman K. Moore, Key West	2nd Thurs.	12
Nassau	David G. Humphreys, Fernandina	John W. McClane, Fernandina	Last Fri.	11
Orange	Eugene L. Jewett, Orlando	Andrew W. Townes Jr., Orlando	3rd Wed.	180
***Osceola**				
Palm Beach	Thomas E. Daly, West Palm Beach	David A. Newman, Palm Beach	4th Mon.	138
Pasco-Hernando-Citrus	Frank Y. Robson, New Port Richey	W. Wardlaw Jones, Dade City	2nd Thurs.	17
Pinellas	Clyde O. Anderson, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	212
Polk	Theodore C. Keramidas, Winter Haven	James T. Shelden, Lakeland	2nd Wed.	89
Putnam	Lawrence G. Hebel, Palatka	James A. Long Jr., Palatka	2nd Tues.	10
St. Johns	James J. DeVito, St. Augustine	Reuben J. Plant Jr., St. Augustine	3rd Tues.	19
St. Lucie-Okeechobee-Martin	Laurance D. Van Tilborg, Ft. Pierce	Adrian M. Sample, Fort Pierce	3rd Thurs.	22
Sarasota	Henry J. Vomacka, Sarasota	Lloyd J. Duest, Sarasota	2nd Tues.	53
Seminole	J. Clifford Boyce, Sanford	Terry Bird, Sanford	2nd Tues.	20
Suwannee	William P. Blackmon, Mayo	Hiram B. Curry, Jasper	1st Sat.	9
Taylor	George H. Warren, Perry	Walter J. Baker, Foley	Last Fri.	4
***Dixie, Lafayette**				
Volusia	Cleland D. Cochrane, Daytona Beach	Robert L. Miller, Daytona Beach	2nd Tues.	84
***Flagler**				
Walton-Okaloosa	Robert von P. Maxon, Fort Walton	Arthur G. Williams Jr., Valparaiso	3rd Thurs.	20
Washington-Holmes	Ralph H. Segrest, Bonifay	Baylye W. Dalton, Chipley		6
			Total	2,653

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1. Cook, M. H.; Free, A. H., and Giordano, A. S.: Am. J. M. Technol. *19*:283, 1953.
2. Gray, C. H., and Millar, H. R.: Brit. M. J. *4824*:1361 (June 20) 1953.

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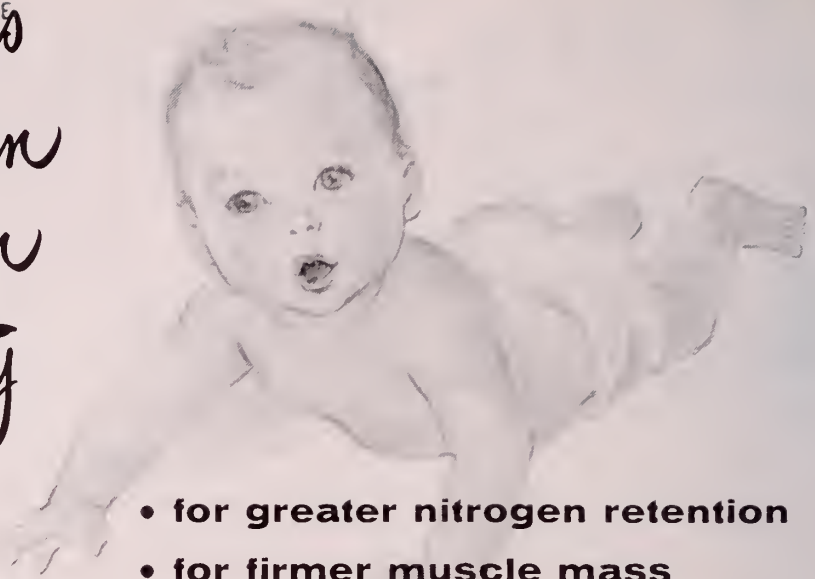
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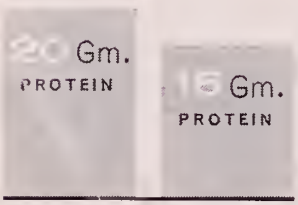
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Recommended Daily Allowance for a 10 lb. infant

1. Jeans, P. C., in A.M.A. Handbook of Nutrition, Philadelphia, Blakiston, 1951, pp. 275-298. 2. Stare, F. J., and Davidson, C. S., in The Proteins, American Medical Association, 1945.

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OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XLI FEBRUARY, 1955 No. 8

Eighty-First Annual Meeting
St. Petersburg, April 3-6, 1955

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Cosmetic Surgery
George W. Robertson III

Intrauterine Pack in Postpartum Hemorrhage
John J. Fisher

Cancers Of The Larynx
J. Brown Farrior, Richard A. Bagby, and Robert G. Iglesias

Health Officers and Private Practitioners
Wilson T. Sowder

Malpractice Insurance Problem
Part III

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Volume XLI | FEBRUARY, 1955 | No. 8

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References
(1) Kirby, W. M. M.; Waddington, W. S., & Doornink, G. M.: Antibiotics Annual, 1953-1954, New York, Medical Encyclopedia, Inc., 1953, p. 285.
(2) Finland, M., & Haight, T. H.: *Arch. Int. Med.* 91:143, 1953.

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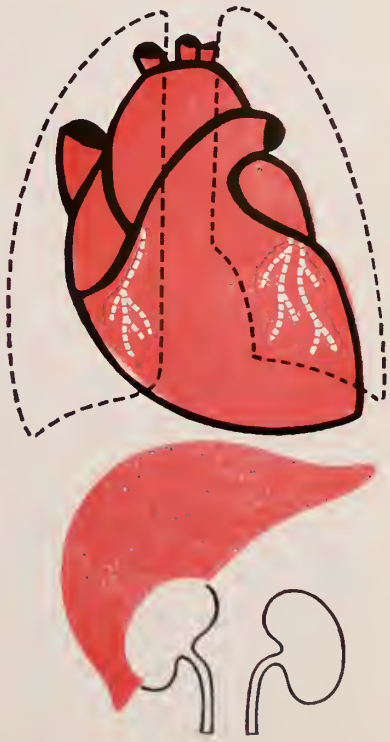
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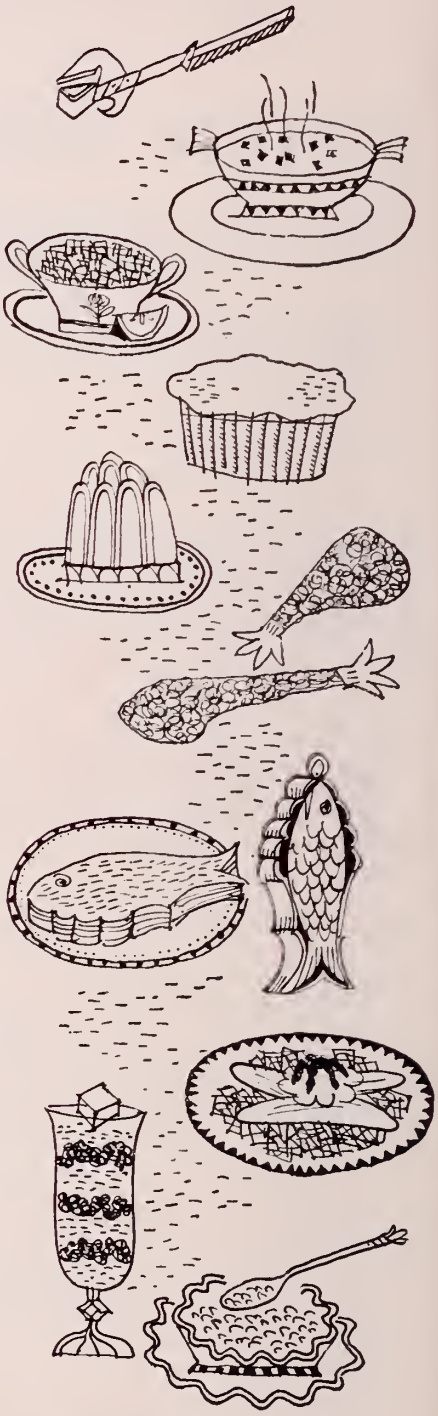
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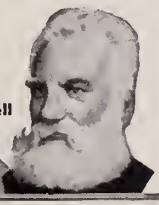
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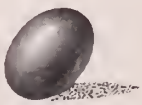
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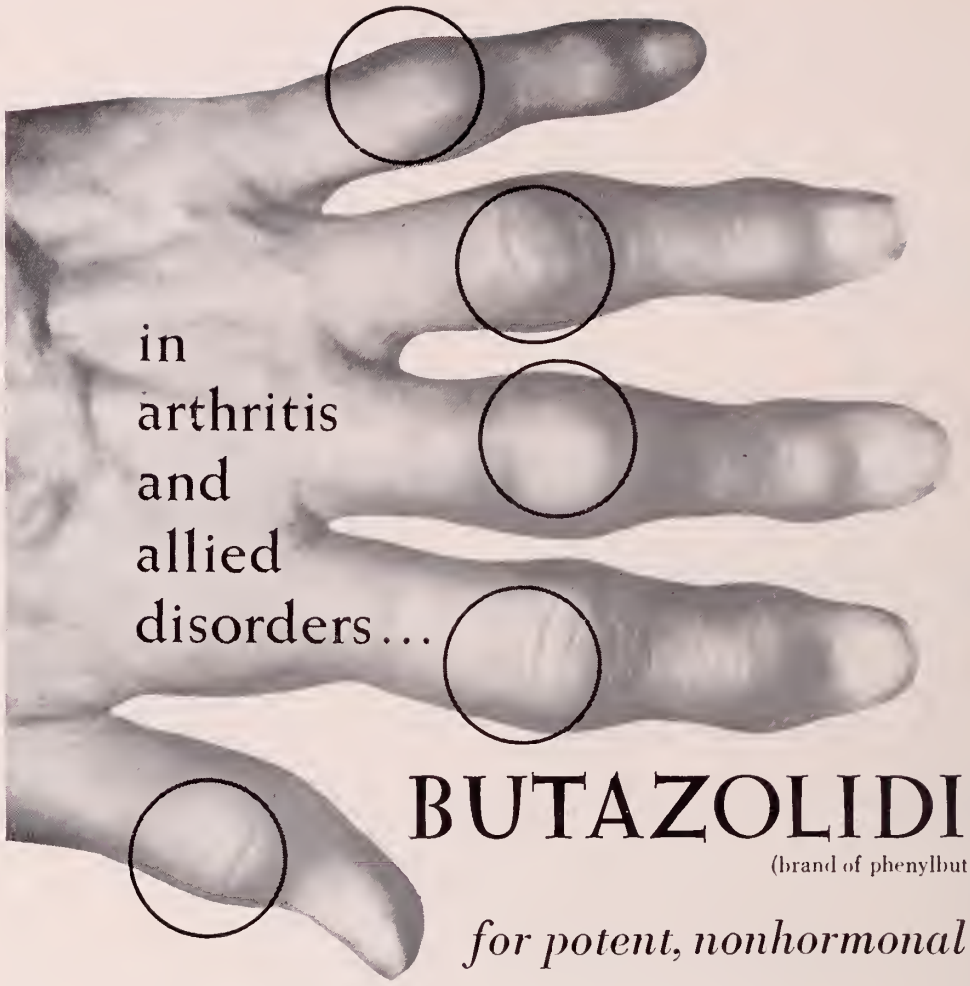
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*MacKnight, J. C.; Irby, R., and Toone, E. C., Jr.: Geriatrics 9:111 (Mar.) 1954.

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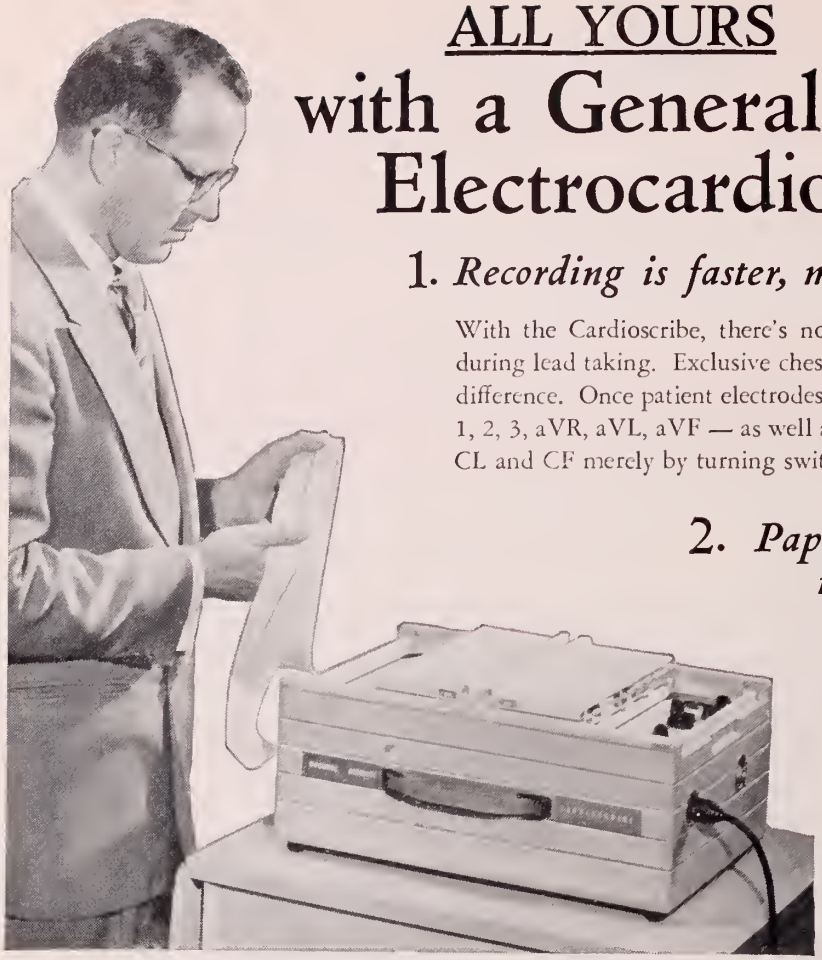
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REFERENCES: 1. Boland, E. W. and Headley, N. E., *J.A.M.A.* **148**:981, March 22, 1952. 2. Ward, L. E., Polley, H. F., Slocumb, C. H. and Hench, P. S., *J.A.M.A.* **152**:119, May 9, 1953. 3. Snow, W. B. and Coss, J. A., *N.Y. State J. Med.* **52**:319, Feb. 1, 1952.

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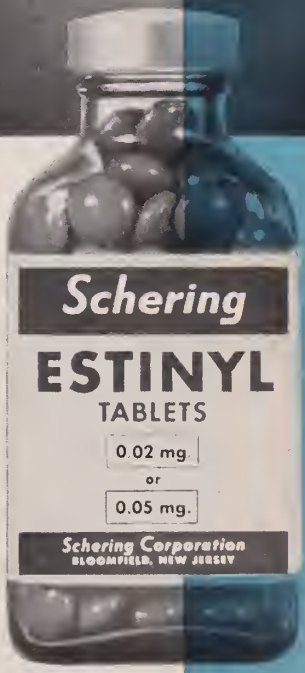
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Cosmetic Surgery

GEORGE W. ROBERTSON III, M.D.
MIAMI

Judging by the evidence, the great emphasis placed on personal appearance did not arise, as one might surmise, with the development of modern advertising, but rather was a boon, or a bane, to ancient man as well as to ourselves. The Ebers Papyrus of 1500 B.C. states that grafting of tissue was practiced by the Egyptians as far back as 3500 B.C., and the sacred Vedas, or holy books, of equal antiquity reveal that both flap and grafting operations were well known among the ancient Hindus. It is interesting to note that the earliest plastic operations were developed for cosmetic purposes, namely, to replace the noses of fellow men who had suffered the ravages of syphilis, the ignominy of defeat in battle, or the penalty for being caught in the act of stealing.

Reconstruction

Cosmetic surgery, which by definition is surgery for the preservation or restoration of beauty, apparently began with the operation of rhinoplasty. Today there are two particular types of rhinoplasty, the first being the so-called restorative rhinoplasty for partial or complete destruction of the nose, and the second being corrective rhinoplasty for abnormalities due to growth, disease, or injury (figs. 1 and 2). The latter is the type most commonly known to the general public, and is actually a combination of a series of operations. These were partially originated, combined and reported by Joseph in 1907. His method is the basis of the intranasal operation for corrective rhinoplasty which is generally used today. It lends itself well to the variations which should be utilized in various cases, since obviously a stock type of nose would not be applicable to all types of face. The reply of one of this country's best plastic surgeons to queries about breathing through the reconstructed nose is, "It's all for show. It's not to blow." Actually, he is careful to restore and maintain function, as is any other surgeon worthy of the name.

Operations for reconstruction of all or portions of the ear are almost as ancient as those for reconstruction of the nose. Because of the structure of the ear, namely, the minute contour, the thinness, and the necessity for skin coverage, both anteriorly and posteriorly, the reconstruction of the ear is perhaps the most difficult feat in plastic surgery today. In contrast, the operations for diminution in size, improvement of contour, and correction of position of the ear, or ears, are relatively simple and highly successful (fig. 3).

In considering structural changes of features, one must take cognizance of operations for changes in the appearance of the jaw. A greatly receding chin, or an exceedingly prominent chin, may be most distressing to the owner, especially if it should be accompanied by an overbite or underbite of considerable degree. A receding chin may be built out merely by the addition of a cartilage, bone, or plastic implant wired to the anterior portion of the mandible (fig. 4). If there is an accompanying underbite, the entire mandible may be moved forward by one of several operations, usually involving sectioning of the ascending ramus, repositioning to a more anterior position, and maintenance of position by means of some occlusal apparatus. The protruding mandible may be recessed either by the same operation in reverse, that is, sectioning the ramus and moving

Read before the Florida Medical Association, Eightieth Annual Meeting, Hollywood, April 26, 1954.

the mandible backwards, or by sectioning the body of the mandible after removing one of the molar teeth.

Up to this point I have been discussing structural changes primarily. Operations upon the skin, or the covering of these structures, also is most important since, as all know, beauty is only skin deep.

One method which has recently received much popular approval involves the use of sandpaper. This method is applicable to many types of scars, but is most commonly used in the case of pitted scars (fig. 6). The sandpapering of the skin does not affect the pits themselves, but instead reduces the thickness of the skin to approximately the level of the pits. In other words, since the surgeon cannot fill up the valleys successfully, he



Fig. 1. R. Z. Rhinoplasty. a and b. Preoperative views. c and d. Postoperative views.



Fig. 2.—J. M. Repair of depressed and flattened nose by L-shaped cartilage strut. a and b. Preoperative views. c and d. Postoperative views.

Facial scarring may occur following trauma of any sort, such as lacerations, avulsions, burns and operations for various reasons upon and around the face. In general the repair of facial scars consists of excisions, undermining and especially fine closures, rotations of flaps to alter the scar line so that the scar then lies in the direction of the normal facial lines, or in some cases, replacement by grafts, or flaps (fig. 5).

abrades the mountains down to the level of the valleys. Pits which extend below the thickness of the skin are impossible to eradicate, but here the sanding operation bevels the edges of the pits to a point where the symmetry of the face is much smoother.

There are other methods of abrasion recommended, notably, use of the rapidly rotating brush, or wheel, but these are far more dangerous than



Fig. 3.—S. T. Otoplasty for protruding ears. a and b. Preoperative views. c and d. Postoperative views. Scar lines increase behind ears.

manual sanding, since a small slip at 2,000 rotations per minute can inflict a considerable laceration. Even manual sanding is not without hazard as it must be remembered that keloids occur in white skin as well as in black, and infection can spread from active acne lesions.

The operation or series of operations for removal of excess wrinkling of the skin is called rhydectomy, which, as with designations of so many other operations, is a misnomer, since the operation does not consist of excising but rather of stretching out wrinkled skin. Face lifting, as it is more popularly called, consists of three series of operations, two or occasionally all of which may be combined. Lower facial and neck wrinkles are usually removed by making incisions completely around the ears, and undermining extensively down around and underneath the chin and around the neck (fig. 7). These incisions are carried forward into the sideburn and back into the hair-bearing area of the neck, in order to remove the excess tissue without wrinkling about the ear. The upper portion of the face is handled by incising across the top of the head and undermining down to the upper eyelids. This procedure allows the upper eyelids and the eyebrows, which tend to sag with age, to be elevated and smoothed out. The lower eyelids require a separate incision, and considerable care should be exercised in the surgical treatment of this portion since the tarsal plate is elastic and an excess pull may cause an ectropion. One need simply pull down on the lower eyelid to find how little tension is required to evert the eyelid.



Fig. 4.—A. T. Receding chin. a. Preoperative view. b and c. Postoperative views showing polythylene mandible.



Fig. 5.— H. M. Facial scar. a and b. Preoperative views. c and d. Postoperative views.

A face lift may last for from two to perhaps seven years, depending upon the type of skin the patient has. In younger persons in whom excessive wrinkling develops, the result of face lifting is less lasting since they have highly elastic skin. In patients in whom the skin does not wrinkle until middle age or later, the results are much more lasting. Subsequent face lifts may be performed when necessary.

The face-lifting operation is often used as an adjunct to operations for suspending the paralyzed face, following removal of the seventh nerve. It is especially valuable if the paralysis is of long duration as the paralyzed face sags much more rapidly than the normally muscled one. The suspension itself is generally accomplished with fascial strips, attached to the temporalis muscle, or by transfer of the masseter muscle, or both.

Mammoplasty

I have purposely left the discussion of mammoplasty to the end since it encompasses alterations of both underlying structure and covering skin. There are in general two types of operation utilized for reducing the size of the breasts. The first and older operation attempts to maintain the breast as a functioning unit. The newer type, and the one incidently which is utilized in the great majority of cases today, is not a physiologic operation. It consists of amputation of the amount of breast tissue desired and transplantation of the nipples as free grafts (fig. 8). Although it is simply an empiric type of operation and violates many of the principles of breast surgery which have been hallowed for years, it is a remarkably successful one and is accompanied by few complications. In contradistinction, the physiologic



Fig. 6.— W. C. Sanding, a and b. Preoperative views, c and d. Postoperative views.

operation, when utilized in cases in which considerable tissue must be removed, is fraught with many dangers. Even in excellent hands, this operation has a complication rate of 25 per cent, and the complications are usually serious ones, such as complete necrosis of a nipple and areola. Today, the physiologic operation is reserved for the elongated breast, in which no tissue needs to be removed.

As a rule mammoplasty is not performed for the purpose of giving the patient beautiful breasts, but rather to achieve normal-looking breasts which fit comfortably into a brassiere of average size. There has been much discussion lately of an operation for enlarging the size of small breasts, which was reported pseudoscientifically in one of the popular magazines. In the hands of ethical physicians, this operation is still in an experimental stage and has many dangerous possibilities. For further comments on this type of operation, I would refer those interested to the report of the Bureau of Investigation of the American Medical Association, which was published in the Nov. 28, 1953 issue of The Journal of the American Medical Association.



Fig. 7. — B. M. Rhydectomy. a. Preoperative view. b. Postoperative view.

Conclusion

In conclusion, I believe that many types of cosmetic surgery, several of which are here discussed, are completely justified by the tremendous psychologic lift they give the patient and the patient's family. Cosmetic surgery often serves as an adjunct of psychotherapy, but one should be extremely careful in the selection of patients, as I cannot stress too strongly the inadvisability of operation upon psychotic patients, or patients with certain types of severe psychoneurosis. Personally, I have found it extremely helpful to enlist the aid of a trained psychiatrist in any questionable case.



Fig. 8. — F. C. Mammoplasty. a. Preoperative view. b. Postoperative view.

When one considers that the American woman spends over one billion dollars per year for cosmetics and over six hundred million dollars per year in the beauty parlor, it would be most unusual to expect her to overlook a much more permanent device for the preservation, or restoration, of beauty.

204 New Pan American Bank Building.

Discussion

Dr. Bernard L. N. Morgan, Jacksonville: I think Dr. Robertson has covered a vast subject succinctly. The whole problem of cosmetic surgery has in the past had a rather unfavorable light cast upon it because it has been misused and mispublicized. I am glad Dr. Robertson was able to bring before the audience today the fact that the cosmetic surgeon, far from being a quack, is really doing something which is of value to his patients both mentally and socially. I was glad to notice that he emphasized some of the newer technics which are being utilized nowadays. In particular I should like to refer to the treatment of the breast — enlargements by the free nipple graft. In the past many of us have really sweated out the postoperative days because of the risk of necrosis of the nipple and consequent deformity. Through the genius of Dr. Milton Adams of Memphis in reintroducing a technic which was first published by Thorek about 30 or 40 years ago, we now have in the free nipple transplant an operation which, as you have seen, is not only most satisfactory cosmetically, but from the point of view of surgical technic and postoperative management much less complicated.

I am glad, too, that Dr. Robertson mentioned the problem of the abrasion methods of reducing scars or acne pitting and other such lesions. He mentioned the dangers of the steel brush. I think in the hands of a competent man it has its place, but as he stated, a whirling disk of 2,000 revolutions per minute can do great damage in a short time, and I think myself that the use of the sandpaper technic wherein the surgeon has individual control of the abrasion effort without the use of mechanical devices is probably a much safer method.

The psychologic problems that many of the patients have are often as great a danger to the surgeon as they are to the patient himself. As has happened in the past, persons come to you greatly dissatisfied with the appearance of their nose and you spend much time and effort to give them a beautiful nose and then they come back and tell you that they are dissatisfied with the looks of their chin. You scratch your head, think a little bit,

and realize that the nose and the chin are just being used as the excuse for some inner psychologic instability, and that you would have been much wiser in the first place to refer them to a psychiatrist.

I think it should be mentioned that one of the most important considerations in the training of a plastic surgeon is not how and when to operate, but, more important, how and when not to operate. There is hardly time for a discussant to go into any great detail on a paper of this nature except once more to emphasize the importance of the medical profession realizing that cosmetic surgery has its place in medicine and, as you have seen from the results Dr. Robertson has presented, that the benefits to the patient both mentally and physically certainly justify every expenditure of time and effort he has put into it.

Present Status of the Intrauterine Pack In Postpartum Hemorrhage

JOHN J. FISHER, M.D.
JACKSONVILLE

The role of the intrauterine pack in the drama of postpartum hemorrhage is today a much disputed one. This formerly reliable and unsuspected adjuvant of the American obstetrician is being assailed in some circles as unphysiologic and inefficacious.

Whereas a review of the literature concerning postpartum hemorrhage does not fall within the scope of this paper, a brief summarization of the proposed methods of management is required as an introduction to the present study. All authorities seem agreed upon the indispensability of a prophylactic regimen, whole blood transfusion, inspection of the birth canal for trauma and retained products of conception, and the administration of a suitable oxytocic. It is when the hemorrhage fails to respond to these procedures that opinion varies as to the further course of management.

Some authors advocate employment of a hot (120 F.) intrauterine douche. Should this fail, they advise abdominal or, if necessary, bimanual compression of the uterus. Some advise immediate bimanual compression without the preliminary douche. These methods failing, hysterectomy is performed. Several modern texts still disregard the douche and compression in their preference for the uterine pack.

The present study was occasioned by criticism of an obstetric case in which the intrauterine pack was employed, the procedure of packing the uterus being termed archaic and no longer a part of good modern obstetrics. Although designed as an answer to such charges, the results of this study are presented on an unbiased basis, and no opinion is expressed concerning the place of the uterine pack in the management of postpartum hemorrhage.

From the Department of Obstetrics and Gynecology, Brewster Hospital, and the Department of Gynecology, St. Luke's Hospital, Jacksonville.

Method

A questionnaire was submitted to the department heads of the 50 maternity centers reporting the greatest number of deliveries according to the 1951 listing in the Journal of the American Medical Association. The form included the following five queries:

1. Is the intrauterine pack ever employed in postpartum hemorrhage in your hospital?
2. If yes, what is the indication?
   - Atony
   - Other (specify)
3. If yes, is its use successful?
   - Always
   - Often
   - Sometimes
   - Seldom
4. If no, what is the objection to its use?
   - Infection
   - Ineffectual
   - Unphysiologic
   - Other (specify)

5. Do *you* believe that the uterine pack is indicated? Sometimes
Never

Results

Replies were received from 37, or 74 per cent, of the maternities questioned. It should be stressed that all the centers whose replies comprise the statistics of this report are accredited teaching centers for resident training and as such should represent not only present day teaching on this point but also the thinking pattern of the newer generation of qualified obstetric specialists.

Among the largest maternity centers replying, 94.6 per cent reported the use of the intrauterine pack in the management of postpartum hemorrhage. Only two, or 5.4 per cent, reported that the packing is never employed (table 1).

Table 1.—Survey of Use of Intrauterine Pack in Postpartum Hemorrhage

	Yes	Per Cent	No	Per Cent
Maternities	35	94.6	2	5.4
Department heads	32	86.5	5	13.5

Atony of the uterus was listed as the indication in 33 instances. Other indications given included: as a temporary control of bleeding from lacerations, 2; following cesarean section for placenta praevia, 2; following cesarean section for abruptio placentae, 1; routine at the time of cesarean section, 1; in cases of low implantation of the placenta, 1; and in cases giving evidence of signs of retention of the fetal membranes, 1.

As for efficacy of the pack, in four institutions it was regarded as always successful when properly used. In 15 it was regarded as often, and in one additional institution as usually, successful. In 20, or 57 per cent, therefore, the results were always, usually or often successful, or good.

Nine centers replied that their experience with the pack has proved the measure to be sometimes successful, or fair. Six maternities listed seldom successful results, or poor (table 2).

Of the department heads replying, 32, or 86.5 per cent, favored the use of the pack when indicated, while five, or 13.5 per cent, were of the opinion that indications for its use never arise.

The reasons for objection to its use included all those listed on the questionnaire plus concealment of bleeding. Whenever its use was objected to, it was upon all counts.

Table 2.—Results Following Use of Intrauterine Pack in Postpartum Hemorrhage

			Per Cent
Always successful	4		
Usually successful	1	Good	57
Often successful	15		
Sometimes successful	9	Fair	26
Seldom successful	6	Poor	17

Discussion

Although all questionnaires must necessarily suffer from inflexibility, the results of this survey allow some conclusions. In only a few of the largest maternity centers is the intrauterine pack never employed nor its employment taught residents in the management of postpartum bleeding. Even the most enthusiastic of its proponents acknowledge that the indication for its employment arises only rarely, especially with good prophylactic management, administration of oxytocics, and liberal employment of replacement transfusion; but few obstetricians of wide clinical experience are willing to assign the intrauterine pack to the obstetric discard heap along with internal podalic version, high forceps, and symphysiotomy.

As is the case with any therapeutic procedure, certain precautions must be exercised for best results. Failure to observe these can lead to tragedy, and undoubtedly such abuse of its proper management has contributed to the decline in popularity of this procedure in some circles. Much the same situation exists concerning Pitocin, but few will agree that its advantages when properly employed shall be denied the experienced obstetrician.

When the packing is employed for postpartum hemorrhage secondary to atony of the uterus, by far its most common indication as evidenced by the answers to the questionnaire, the birth canal must be inspected thoroughly for laceration. A ruptured uterus contraindicates use of the pack. Lacerations of the lower portion of the birth passage naturally will not respond to packing the uterus above, and should be ruled out by careful inspection and repaired when found.

It should be remembered always that packing the uterus is part only of a general management of this emergency. Whole blood transfusion should be just as enthusiastically employed to replace previous blood loss, while the pack controls further loss.

The procedure of packing must be thorough to be effective, the initial packing being introduced to the fundus and solidly held there by firm packing from that point downward.

Once the pack is in place, the patient should be observed closely and frequently. The cessation of external hemorrhage should not occasion a premature lessening of vigilance. The level of the top of the fundus should be marked on the anterior abdominal wall, and comparison made frequently to this point. Careful adherence to this precaution precludes concealed hemorrhage behind the packing.

Antibiotics should be administered routinely, not only on the basis of the packing but also because this has usually been preceded by repeated manipulation.

Summary

A survey concerning the popularity of the intrauterine pack in the management of postpartum hemorrhage is reported.

The pack is employed in 94.6 per cent of the largest maternities in this country replying to the questionnaire.

The results reported are good in 57 per cent, fair in 26 per cent, and poor in 17 per cent of those institutions reporting its use.

A brief discussion concerning the proper use of the intrauterine pack is presented.

800 Lomax Street.

Operations of Choice in Cancers of the Larynx

J. Brown Farrior, M.D.
Richard A. Bagby, M.D.
AND
Robert G. Iglesias, M.D.
TAMPA

The complete cancer surgery of today is curing more cases of cancer of the larynx than were being cured 10 years ago. The operations of today are more thorough and include block resection of those areas which might be involved in an unrecognized extension of the disease. Following this principle, today's laryngofissure includes the anterior commissure, the face of the thyroid cartilage, and the cartilage underlying the carcinoma; today's laryngectomy is a wide field block resection of the larynx and adnexa; and today combined laryngectomy and neck resection is saving the lives of many patients in which the lesion was formerly considered inoperable. The principle of this complete surgery is to get at least a step or two ahead of the invading cancer.

From the Department of Otolaryngology, Tampa Municipal Hospital, Tampa.

Read before the Florida Society of Ophthalmology and Otolaryngology, Fifteenth Annual Meeting, Hollywood, April 25, 1954.

In the early development of laryngeal surgery, otolaryngologists were faced with the problem of a contaminated wound, the ravages of infection, high mortality, the secondary fistulas, and prolonged convalescence. These obstacles were overcome by the principles of narrow field surgery. These obstacles and the narrow field surgery excluded the possibility of surgical removal of the more extensive carcinomas and in about 40 per cent of the cases the lesion was classified as inoperable. The patients were formerly "turned out to pasture" to die, to die grazing on irradiation. With our wonder drugs and anesthetics, today's otolaryngologists are able to operate upon and with complete cancer surgery frequently cure the extensive carcinomas.

Most of us were taught the principles of the early "narrow field" otolaryngologists with the clearcut didactic indications for laryngofissure, laryngectomy, and inoperability. Today, the

laryngectomy and neck resection, the wide field laryngectomy, and the block resection type of laryngofissure have been added to our armamentarium. These are changing times, and the goal of this presentation is to give our current concepts of the operations of choice in cancer of the larynx.

Roentgen therapy can and will cure a nearly comparable percentage of early lesions of the vocal cords. In our opinion this therapy is the treatment of choice in early superficial lesions when the anterior ends of both vocal cords are involved without fixation. In such lesions, we recommend

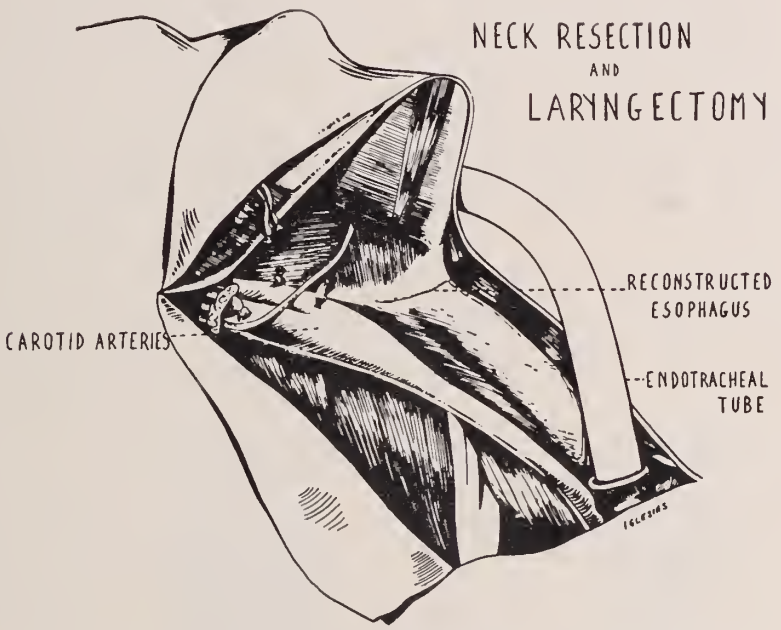


Fig. 1.—Combined laryngectomy and neck resection is curing many cancers which were formerly regarded as inoperable. In this block resection, all cancer-bearing tissue is removed including the larynx, lymphatics, sternomastoid muscle and jugular veins.

Cancer of the larynx is a disease localized within the larynx and the neck. Because of the early symptom of hoarseness and this localization, otolaryngologists have always been able to cure a higher percentage of carcinomas than is generally possible in the other divisions of surgery. For years otolaryngologists have reported cures of 80 to 90 per cent or better with laryngofissure, and cures of 60 to 80 per cent with laryngectomy. Five years from now when the current concepts of complete cancer surgery have reached maturity, we predict that these cure rates will be improved 10 to 20 per cent in those cases in which the lesions were previously regarded as operable and that the greatest saving of lives will be through the application of the principles of complete surgery in those cases in which the lesions were previously regarded as incurable.

roengten therapy over total laryngectomy. When the lesion involves the free border of one cord, we recommend laryngofissure, but we have no argument with those who recommend irradiation. We discuss this possibility with the patients, and if they select roentgen therapy, it has our endorsement. In our opinion, however, this therapy should never be the primary treatment of an extensive but resectable intrinsic or extrinsic lesion.

The work to be presented today is part of a series of 166 major cancer operations, the least of which is laryngofissure and the greatest a bilateral neck resection and mandibulectomy. In all cancers of the head and neck the immediate operative mortality is 0.6 per cent and within the first postoperative month 3 per cent. In the 73 cancers of the larynx which we have operated upon, the immediate operative mortality is 0.

One patient died of an apparent coronary thrombosis one week following a combined laryngectomy and neck resection. Thanks to excellent medical anesthesists, we are well pleased with our operative mortality. Thanks to the concepts of complete cancer surgery, we are well pleased with our apparent cures.

As the primary purpose of this portion of this program, we want to present first a few principles of the surgical technic of the wide field laryngectomy and of combined neck resection and laryngectomy. Secondly, we want to discuss a series of cases of carcinoma of the larynx giving our reason for the choice of operations, discussing particularly the borderline cases and the cases in which, in the development of these concepts, we have failed to obtain a cure.

Combined Laryngectomy and Neck Resection

Combined laryngectomy and neck resection is indicated when there is a resectable lesion of the larynx with probable extension to the cervical lymph nodes. In this operation the larynx, sternomastoid muscle, jugular vein, and all lymph-bearing structures from the base of the skull to the clavicle (fig. 1) are removed in a single block. To the patient the discomfort is little, if any, greater than that of a simple laryngectomy.

The specific indications for combined laryngectomy and neck resection are:

1. A resectable lesion of the intrinsic or extrinsic larynx with palpable, movable cervical lymph nodes.
2. Subglottic extension of a carcinoma of the larynx even without palpable cervical lymph nodes. In these subglottic extensions the incidence of silent cervical metastasis is so great that this type of lesion is a positive indication for the so-called prophylactic neck resection.
3. Extensive extrinsic carcinoma of the larynx without palpable nodes is a probable indication for the combined laryngectomy and neck resection.
4. Complete fixation of a single vocal cord is in some teaching centers being regarded as an indication for the combined "L & N." Actually with complete fixation there is usually subglottic extension, which is a positive indication for the combined neck resection.
5. A resectable lesion of the intrinsic or extrinsic larynx with bilateral freely movable lymph nodes is an indication for combined laryngectomy and bilateral neck resection.

Review of Cases

Of our 36 neck resections, 11 were performed for cancer of the larynx; 9 were combined operations, and 2 were secondary neck resections. Of the patients subjected to the combined operation, 7 have been apparently cancer-free from a few months to three years. In both of the cases in which the patient died, the nodes extended upward to the jugular foramen. In one of these the junction of the carotid arteries was involved and required resection of the carotid artery. There were no complications from the resection of the carotid artery itself.

The third patient died from cancer of the stomach. He lived happily for four years after a palliative laryngectomy and for three years after the secondary neck resection. Prior to surgery, this patient had been living in a county home for months, having been put there to die of cancer of the larynx. Almost six months later, he was referred with respiratory difficulty for a tracheotomy. As stated, we performed the tracheotomy and palliative laryngectomy and later neck resection.

Of the 11 cases in which we performed neck resection, in 8 the patients are living, well, and apparently cancer-free. A few years ago all of the lesions in these cases would have been regarded as inoperable.

Laryngo-pharyngo-esophagectomy and Neck Resection

One patient with a pyriform fossa lesion and cervical metastases proved to have an almost annular involvement of the upper part of the esophagus at the cricopharyngeus. This required resection of the lower portion of the pharynx and the upper portion of the esophagus, in addition to the laryngectomy and neck resection. Secondarily, we reconstructed an esophagus from the skin flap and covered the area with a skin graft. Immediately postoperatively we wondered if our efforts had been worth while. Now, 15 months later, the patient is cancer-free and happy; so is the surgeon.

Upper Laryngectomy and Posterior Glossectomy

By and large, we believe that we should adhere to a classical wide field laryngectomy and the classical complete neck resection. Because of the peculiar character and specific location of the disease, we have in two instances diverged from this opinion and have performed what might be

called upper laryngectomy and posterior glossectomy with partial neck resection. The lesions in these cases involved the top of the epiglottis and posterior part of the tongue. We removed the top half of the larynx just above the false vocal cords and the posterior one third and two thirds, respectively, of the tongue in a single block resection removing the upper cervical lymph nodes bilaterally. The nodes gave no evidence of disease on frozen section examination. In view of the gravity of the surgery, we did not feel justified in proceeding with what was apparently a prophylactic neck resection. It has been most gratifying to see how well these upper-laryngectomized patients have done. The one in whom we removed the posterior third of the tongue has had no difficulty at all. The one in whom we removed the posterior two thirds of the tongue and the involved right hypoglossal nerve has mastered the technic of swallowing, has excellent morale, and has been cancer-free for more than one year. She had a mucoepidermoid carcinoma about 11 cm. in diameter. The mucoepidermoid carcinomas tend to remain well localized. By all didactic standards, this lesion was grossly inoperable and incurable. Now, however, more than a year postoperatively, the end result seems to justify this heroic and heretical surgical procedure.

In the cases of wide field laryngectomy, we had one lesion of the tip of the epiglottis. In retrospect, we would now perform an upper laryngectomy and posterior glossectomy, and in so doing believe that we would give this patient the same apparently cured result without removing the vocal cords.

Wide Field Laryngectomy

The advantages of wide field laryngectomy are that it removes those two locations to which the carcinoma is most likely to extend and that it gives a wider margin of safety around the carcinoma (fig. 2). The preepiglottic space and the tissue in front of the thyrohyoid membrane are removed en bloc with the larynx. At least the central arch of the hyoid bone is removed with the larynx. In carcinoma of the vallecula extending on to the base of the tongue a goodly portion of the base of the tongue can be removed. If a laryngectomy is to be performed for carcinoma of the larynx, that laryngectomy should include all tissue which would give the widest possible margin of safety and insure the possibilities of a permanent cancer cure.

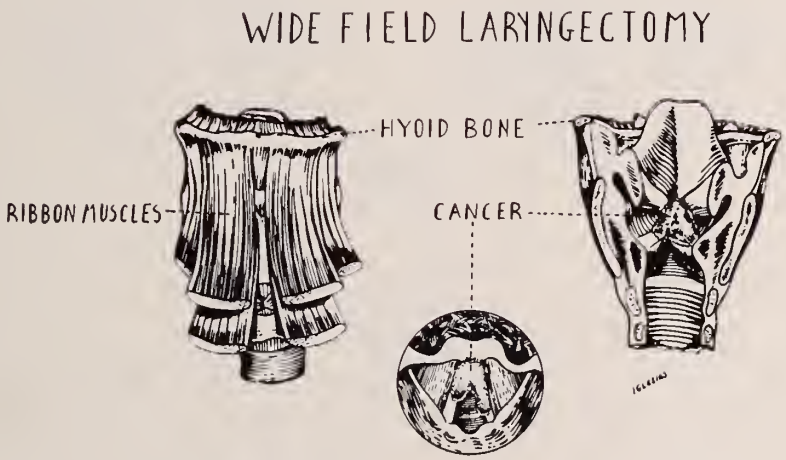


Fig. 2.—The wide field laryngectomy includes the larynx and adnexa. This additional margin of safety results in a higher percentage of cancer cures.

The purpose of the expanded technic of the wide field laryngectomy is to remove the larynx and adnexa in order to get one or two steps ahead of the points of invasion of the carcinoma.

The wide field laryngectomy is to us the routine type of laryngectomy. There may remain a place for the older type narrow field and subperichondrial laryngectomy. This place is limited. It is limited to those carcinomas which involve only the free borders of both vocal cords, without appreciable fixation. When a surgeon employs

the narrow field type of laryngectomy, we believe that he should explain his reason.

Analysis of Laryngectomies

Of the 47 laryngectomies, 35 were classical laryngectomies, 3 we classed as palliative, and 11 were combined with neck resection.

Of the 33 patients undergoing classical laryngectomy, 1 patient died of carcinoma and 1 has metastatic lesions in the lung. Thirty-one have shown no evidence of carcinoma over a period of a few months to more than five years postoperatively. One patient died of congestive heart failure three years postoperatively at the age of 87. A few years ago in half of these cases the lesion would have been classified as inoperable.

We feel responsible for the death of the 1 patient who died of cancer following the classical laryngectomy. This patient initially refused a laryngofissure and returned several months later with fixation of the vocal cords. We performed a classical laryngectomy, which revealed a subglottic extension of the tumor. When cervical metastases developed later, the patient refused secondary neck resection and died. Had we performed a primary combined laryngectomy and neck resection on this subglottic lesion, this patient might well be cancer-free today.

The patient who now has metastatic lesions in the lung had an extensive carcinoma which involved the pyriform fossa and half the circumference of the opening of the esophagus. We followed the laryngectomy with radiation therapy. This patient has been living happily and apparently well for three years. He looks good now. Roentgenograms of the chest, however, show metastatic carcinoma, and as yet we have found no other primary lesion. The neck, food, and air passages are cancer-free. A woman with a similar lesion elected to have roentgen therapy; the lesion melted away only to recur and cause her death within a year.

The 3 palliative laryngectomies were performed in cases in which the patients were referred with respiratory distress for tracheotomy. By all standards, the extensive carcinomas (filling the entire larynx in these cases) would be regarded as inoperable. We performed the palliative laryngectomies to remove the carcinoma from the food and air passages. One patient died a year later. Two required secondary neck resection and remained cancer-free, 1 later dying of a gastric lesion. In retrospect, circumstances permitting, we would perform primary combined neck resection and laryngectomy in such cases as curative procedures.

Incidence of Laryngectomies

Insurance statistics and accumulated cases reveal a national average of about 5 laryngectomies per million population per year. The State of Florida should average about 20 laryngectomies per year.

Rehabilitation

Esophageal Speech

Thanks to Maj. Logan J. Rooney, a laryngectomized patient, most all of our laryngectomized patients have learned esophageal speech. Major Rooney has a good esophageal voice and is a most patient teacher. For the past several years, we have had an excellent class in esophageal speech at the University of Tampa under the direction of the Vocational Rehabilitation Service. This class was started by Mr. James Lee and then taken over by Major Rooney. All of the laryngectomized patients with Major Rooney work together to help one another. Their morale is almost uniformly excellent. With rare exceptions, cured cancer patients are happy patients.

Partial Laryngectomy (Laryngofissure)

The laryngofissure of today is a block resection of the involved side of the larynx (fig. 3). This block resection includes the face of the thyroid cartilage, the cricothyroid membrane, and the wing of the thyroid cartilage which underlies the carcinoma. This is in contrast to the early types of laryngofissure which merely split the larynx and removed the involved vocal cord. The reason for this more complete cancer surgery is that the slow-growing carcinomas of the vocal cord invade first the anterior commissure, secondly the adjacent cricothyroid membrane and thirdly the underlying cartilage. The block resection of these areas puts the surgeon one or two steps ahead of any possible extension of the carcinoma and insures a permanent cure.

This block resection type of laryngofissure does not greatly extend the indications for laryngofissure or greatly alter the indications for total laryngectomy, but it does and should give a higher percentage of cures, particularly when the lesion involves the anterior commissure. The indications for laryngofissure are then: an intrinsic carcinoma of the larynx which involves the free border of the vocal cord without producing fixation of that cord; the lesion may extend to the

anterior commissure and possibly to a few millimeters on the opposite cord. When much of the opposite cord is involved. roentgen therapy or laryngectomy is indicated.

This type of block resection partial laryngectomy is our routine. We do not perform the older type of simple laryngofissure. This old type of laryngofissure may have a place in the treatment of small lesions, but when a surgeon uses the narrow margin technic, he should give his reason.

In 1 case we performed a total laryngectomy when a laryngofissure might possibly have been adequate. This patient had been subjected to biopsy elsewhere. We interpreted the resultant fixation as extension of the carcinoma and performed the total laryngectomy. The moral of this experience is that in extensive lesions, it does not matter who performs the biopsy, but in borderline lesions the laryngeal surgeon should have the privilege of examining the larynx before it is disturbed by a biopsy. He is then better able to judge the extent of the surgery which will be required.

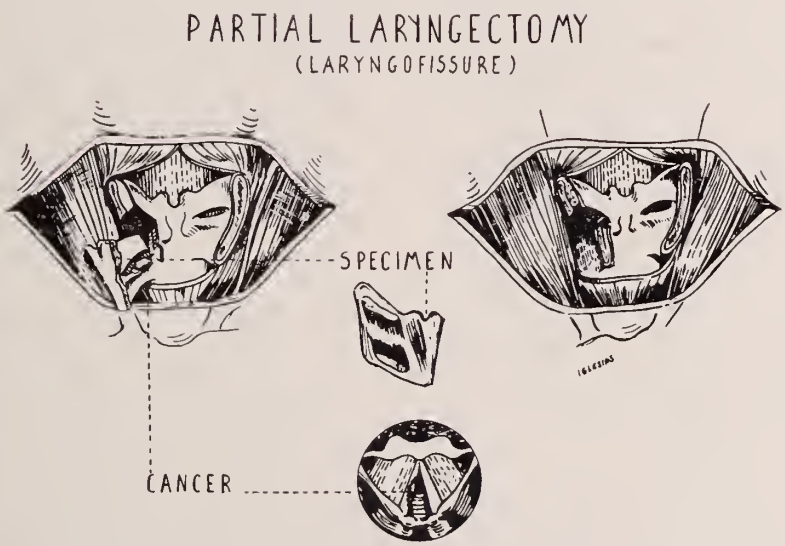


Fig. 3.—Today's laryngofissure is a partial laryngectomy which includes the possible areas of invasion to get a step or two ahead of the carcinoma.

Analysis of Cases

In this series of 74 surgical cases of cancer of the larynx, there were 27 in which partial laryngectomy (larygofissure) was performed. In these cases the postoperative period varies from a few weeks to six years. All of the patients have remained cancer-free and to date all are apparently cancer-cured. One patient died of bronchial asthma and another of ruptured aortic aneurysm; autopsies on both showed no residual carcinoma.

Borderline cases deserve mention. In the larger unilateral lesions, we prepare the patient for a laryngofissure and/or a laryngectomy. If after laryngotomy and direct examination there is still doubt of cure through laryngofissure, we proceed with a total laryngectomy. In this series there were 4 cases in which we hoped to perform a fissure, but found laryngectomy more advisable.

In a similar case we performed a total laryngectomy in which we might now utilize roentgen therapy as the primary treatment of choice. The patient had a superficial type of carcinoma involving the anterior two thirds of both vocal cords without fixation of the vocal cords. Two biopsies had previously been performed, and we interpreted the reaction from the biopsies as evidence of fixation. Although laryngectomy is the classical treatment of choice in this type of case, we would have been most happy to try roentgen therapy primarily for this freely movable lesion. In a similar case in which we utilized primary roentgen therapy, the cancer has been arrested for 18 months.

One patient for whom we advised a laryngofissure elected to have roentgen therapy. This patient had a rather large lesion of the vocal cord but still within the resectable range of a partial laryngectomy. We thought that the lesion was too big to be treated by irradiation therapy. Roentgen therapy was given contrary to this advice. The patient died a tracheotomized death spitting up foul necrotic carcinoma.

Inoperability

As carcinoma of the larynx tends to remain localized within the larynx and neck, few if any lesions should be regarded as inoperable because complete cancer surgery offers the patient a chance to live and, failing this, the greatest possible palliation. Palliative irradiation therapy leaves the patient with a tracheotomy and a necrotic throat requiring continuous nursing care. Conversely, with a palliative laryngectomy, there is a chance for cure; the disease will be removed from the food and air passages, and without the larynx roentgen therapy will be more effective against recurrences. Failing cure, the laryngectomized patient has a far more gentlemanly death than the tracheotomized irradiated patient who dies sloughing and spitting foul necrotic carcinoma.

1. Increasing age is to us a greater indication for surgery than it is a contraindication. In this series we operated upon 21 patients in the eighth and ninth decades of life with no operative deaths. In our opinion these patients survive surgery as well or better than they do irradiation. Hence, in the aged the indications for cancer surgery remain unchanged with the possible exception that we might favor irradiation therapy for a small freely movable lesion on the free border of the vocal cord. Again, the more extensive lesions are a contraindication to irradiation therapy and are an indication for surgery. In Florida, we see an increasing number of these elderly patients. They love life and enjoy their lives more when they have a chance to live.
2. Complete fixation of the cervical lymph nodes is a contraindication to surgery.
3. Invasion of the platysma with dimpling of the skin is probably a contraindication to surgery because when this has occurred, the lesion has probably extended beyond the reach of a neck resection.
4. Distant metastases rarely occur, but if they are definitely present, they may be a contraindication, though laryngectomy may still offer palliation.
5. Bilateral movable metastatic nodes, involvement of the jugular vein and involvement of the vagus nerve are not contraindications to surgery. Involvement of the carotid artery may not be a contraindication to surgery. We have resected one carotid artery and attribute the absence of complications to the preoperative block of the cervical sympathetic nerves and the patient's age of 55. Otolaryngologists, however, are resecting and reconstructing the carotid artery.
6. Annular lesions of the hypopharynx and upper portion of the esophagus may be within the reach of surgery. We have performed 1 laryngectomy-pharyngectomy, upper esophagectomy and neck resection with a secondary reconstruction of the esophagus. The patient is apparently cancer-free 15 months postoperatively.

We do not like to leave a patient to die. In the large lesions we believe that if there is the slightest possibility of resecting the lesion, complete cancer surgery is the only treatment. Even in the more extensive lesions of the intrinsic and extrinsic larynx, the otolaryngologist has a greater opportunity to save the patient's life than is usually possible in cancer of the stomach, lung, or esophagus. The goal of this type of surgery is to save the greatest number of lives and give the greatest possible palliation and not to report the highest possible statistical percentage of cures. To achieve this goal, most every patient should be given a chance, and there can be few contraindications to surgery.

Postirradiation Recurrences

Two additional cases were referred for tracheotomy following roentgen therapy. With laryngoscopy it was impossible to tell whether the obstruction was caused by irradiation reaction or cancer. Later, in both cases recurrence of the carcinoma was proved. These cases now haunt us, for we could have given the patients a chance and certainly greater palliation by laryngectomy.

In 1 of these cases amputation of the epiglottis was followed by roentgen therapy. We are opposed to amputation of the epiglottis, preferring the resection described earlier.

In the second case the patient was advised by an excellent otolaryngologist in Michigan to have

a laryngofissure. The patient, an educated man, read in the lay magazines of the magic of the "cobalt bomb." He went to Canada for this therapy. When the cancer recurred, his neck was so badly burned that we were afraid to attempt surgery. Now we wish we had removed the larynx for the worst fistula would have been better than his miserable death.

Summary

The complete cancer surgery of today is effecting cure in more cases of cancer of the larynx than 10 years ago.

In those cases in which the lesion was formerly classified as inoperable the patients are now being given an excellent opportunity for survival through the combined laryngectomy and neck resection and/or the wide field laryngectomy.

The wide field laryngectomy gives the patient an additional margin of safety and places the surgeon a step or two ahead of the possible invasions of the carcinoma.

The laryngofissure of today is a partial laryngectomy with block resection of possible areas of invasion, again placing the surgeon at least one step ahead of possible sites of invasion.

In this series there were 36 neck resections, 11 of which were performed for carcinoma of the larynx.

Of the 47 laryngectomies, 11 were combined with neck resection; 3 were classified as palliative and 33 as classical laryngectomies.

There was 1 case of laryngopharyngectomy with neck resection and secondary reconstruction of the esophagus.

As a result of the 11 laryngectomies and neck resections, 9 of the patients are alive and cancer-free. Following the 3 palliative laryngectomies, 1 patient was given an additional year of life, and 2 were apparently cured. The 33 total laryngectomies have resulted in 1 patient dying of cancer and 1 having a metastatic lesion; the 31 others have remained cancer-free.

A few years ago many of the cancers in these cases would have been classified as inoperable.

As a result of the 27 laryngofissures (partial laryngectomies), all of the patients have remained cancer-free from a few months to six years.

Because of the complex nature of carcinomas, there can be no routine operation. There is a vast difference in the types of laryngofissure and in the types of laryngectomy. A narrow margin may result in the patient's death while a wide margin and adequate primary surgery will result in a cancer cure.

Acknowledgements: Most of the ideas expressed have been assimilated from the laryngologists of this country. Particular admiration is expressed for the work of Broyles, Ogura, Schall, Clerf, Tucker, Jackson, LeJeune, Orton, Work, Cunning, Hollinger, New, Figi, and Erich, all of whom have many articles in the literature. For brevity, detailed bibliography is omitted.

Both in the operating room and in compiling data, Dr. M. R. Himalstein has been a great help.

Bayshore Boulevard at Hyde Park Avenue.

Discussion

Dr. Millard F. Jones, Jacksonville: I was fortunate to read a draft of this paper before it was presented. Dr. Farrior and his associates have stressed the importance of early and extensive surgery when indicated. Their results have been remarkable, and I believe they surpass any that I have seen published to date. I am in full agreement with their ideas of complete cancer surgery of the larynx.

I believe we are all in agreement on indications for partial laryngectomy — that is, the small noninfiltrating type of lesion, limited to the true vocal cord, without producing fixation of that cord. The lesion may extend to the anterior commissure, or a few millimeters beyond. Dr. Farrior's technic on partial laryngectomy is excellent, in that he opens the larynx on the uninvolved side so as to be sure not to cut through carcinoma. I routinely perform a tracheotomy and remove the tube in two or three days, but this is a personal preference and has no bearing on end results.

Dr. Farrior has stated that when much of the opposite cord is involved, roentgen therapy or laryngectomy is indicated. In my brief experience, I have never recommended roentgen therapy in these early lesions that I thought were curable by partial or complete laryngectomy, except in those cases in which the patient refused surgery. I have been disappointed in the results in the early lesions treated by roentgen therapy. I am sure from published reports that those early noninfiltrating lesions are amenable to control by irradiation. Dr. Del Regato has expressed this well in stating, "A new generation of surgically well trained laryngologists has become naturally fond of what they have learned to practice, and naturally contemptuous of a radio therapy which is often limited to the advanced or recurrent case, or which is entrusted to the uninterested or unskilled occasional performer."

In a discussion of choice of operations for laryngeal cancer we must not forget the transoral approach described by Dr. LeJeune. Dr. LeJeune has ably demonstrated that those carcinomas of the vocal cords that satisfy his rigid requirements may safely be removed by the transoral approach.

Last year, in reviewing the hospital records in Jacksonville for the past 13 years, Dr. King, Dr. Taylor and I found 47 cases of carcinoma of the larynx. Many of the records are incomplete and do not lend themselves well to statistical analysis.

The records show 8 cases in which laryngofissures were performed, the first one in 1949. Six of the patients are living, and 2 have died.

There were 14 cases in which treatment consisted of laryngectomy alone. In the first of these, the operation was performed in 1941 by Dr. King; the remaining 13 occurred from 1949 to the present time. Ten of the patients are surviving, and 4 have died.

There have been 3 cases of laryngectomy and neck dissection, the first one in 1951. All three patients are living, but one has distant metastases.

There were 2 cases of laryngectomy and roentgen therapy combined, both occurring in 1948. In 1, the patient died a year later; the other patient is living.

There were 20 cases of cancer of the larynx treated by roentgen therapy alone, beginning in 1946. Five of the patients are living, all less than two years postoperatively, and three of them have recurrences.

In Jacksonville today we are performing the more complete cancer surgery of the larynx as described by Dr. Farrior, and I am sure our results will justify this type of surgery.

Volume XLI
Number 8

Relationships Between Health Officers and Private Practitioners

Wilson T. Sowder, M.D.
JACKSONVILLE

While a health officer who has good relationships with his medical profession may not necessarily be entirely successful with his work, it is, on the other hand, practically impossible for him to do good work without proper relationships and understanding with his fellow physicians in private practice. It should not be necessary to point out the desirability of belonging to your local medical society and attending the meetings regularly for this is necessary as a preliminary to developing mutual understanding of the problems with which both parties are concerned. I shall not burden you with too many homilies on the subject because most of you are quite as well versed on the subject as I am and quite as well prepared to make this talk. I shall try, however, to make a few points based on my own personal observations over a number of years.

A few physicians in the field of public health seem to harbor the idea that public health and private practice are fundamentally incompatible and that there is a natural and inborn difference in the philosophies concerned with each. Political controversies over a number of years with reference to "state medicine," "socialized medicine," and "socialism" in general have done much to promote this idea among some who fail to study the matter sufficiently. Actually there is, and always has been, a need for publicly employed physicians as well as for private practitioners. The need for public health physicians is certainly not a new one. John Gorrie, inventor of the first ice-making machine, was connected with the United States Marine Hospital in Apalachicola; Walter Reed, who proved that yellow fever was transmitted by a mosquito, was an Army doctor; Goldberger, who found that pellagra was caused by a nutritional deficiency, was a medical officer in the United States Public Health Service; and the role of rats and rat fleas in the transmission of typhus fever was discovered by medical officers of the public health service.

State Health Officer.
Read before the Florida Health Officers' Society, Ninth Annual Meeting, Hollywood, April 25, 1954.

Common Problems

The Florida State Board of Health from its beginning has been concerned with many problems which also have been of paramount importance to private practitioners of the state. Yellow fever was certainly the concern of both, and the disease could not have been eradicated from Florida and the United States by merely treating those who were ill. In the early years the State Board of Health operated isolation hospitals for such communicable diseases as smallpox and yellow fever; and later on private physicians were paid for the care of persons with smallpox on a fee basis much as they recently were in the case of cancer. Physicians were employed by the State Board of Health 40 years ago to take care of crippled children long before the Crippled Children's Commission was established. We therefore can be sure that the problems before us today are not altogether new.

There is no doubt, however, that there has been a growth of the philosophy that the government should take over the practice of medicine entirely, and all of us agree that this is wrong. I am proud of the fact that public health physicians throughout the United States have opposed it along with their brethren in private practice. One thing that we know, and I am not sure that the general medical profession knows it, is the fact that a system of socialized medicine almost inevitably means the decline or end of public health and preventive medicine as we know it. The reason for this is that when large amounts of money are appropriated for medical care through governmental agencies, the prevention of disease, which is a long range program, is neglected or forgotten. Furthermore, in such a medical care plan, physicians lose the leadership because it is considered a welfare program and so much money is involved that financial experts and social workers are believed to be more competent in policy-making and administration. The physician is considered to be a highly specialized technician, and his pride is salved by being told that

he is too valuable to waste his time on broad social and economic problems.

Our interests therefore are the same as those of our fellow physicians in private practice. Furthermore, I believe that our interests are the same as those of the general public, and that the public interest is better served by strengthening the private practice of medicine and by the delegation of only those problems to public health which cannot be handled adequately on a retail basis in private practice. I therefore am strongly of the opinion that the first step in getting along with private practitioners is the cultivation of a personal conviction on your part that you have the same philosophy and interests and that there is no need for antagonism or conflict.

Remember first of all that you were a physician before you were a health officer. You have specialized in the field of public health and preventive medicine just as some of your classmates have specialized in other fields. This fact does not mean that you have to agree with the views of every practicing physician. Such agreement is impossible because it is obvious that all practicing physicians do not agree with each other. Remember also that although we do have problems in our relationships with the general medical profession, which are at times difficult, so do other specialists in the field of medicine. If it were possible for you to attend all of the meetings of the various societies of specialists meeting today, you would find that each of them has many problems concerning relationships with the medical profession as a whole. Frankly, we are in an even better position to get along with all doctors than almost any other specialty. Private practitioners are in competition with each other whereas we are not in competition with them. We are therefore in the happy position of being neutral and can and should play a neutral role in so far as most of the internal problems of the medical profession are concerned. We should remember this, practice neutrality, and not take sides when fellow physicians in the community have disagreements.

Working Together

Your work, however, is peculiar in that it is of interest and concern to all doctors even more than it is to other people in the community. You therefore should not only keep your medical profession acquainted with your work and plans, but you should ask the advice of its members on new programs and procedures. Of course asking is not always easy because there is so much difference of opinion among physicians, as is natural among all human beings. Working closely with the public health committee of the county medical society is the best assurance of proper understanding, but it is important to go beyond this formal relationship. All of you have personal friends and confidants among the physicians in the community. I recommend strongly that you not only cultivate the friendship of all your doctors, but that you pay special attention to those who are leaders in the profession in your community. Pick out one or more who stand out in your society and make them your personal advisors on an informal basis. These are usually older men who have had long experience in medical affairs. Such a friend or friends can be of inestimable help to you in deciding what should and what should not be taken up formally with your county society. They may not be on the public health committee, but their value to you will not be diminished if you have their friendship.

Always approach your doctors in a frank and open manner and get away from any feeling you may have that you need to put your plans across by subterfuge. Remember that you are a member of the profession and can expect the same courtesy as any other member of the profession in the consideration of your problems. You do not have a subordinate role in the affairs of the medical profession. Your position is important, and you will command respect if you deserve it. Deal with your physicians as one of them and not as an outsider asking favors or demanding a reluctant concurrence to your preconceived ideas.

I know that most of you can add many worth while suggestions to these that I have given, but perhaps this talk will stimulate you to give even more attention to the subject. All of us want, and need to have, the respect and good will of our medical colleagues. I know of only one relationship that contributes more to the efficient and tranquil performance of your duties, and that is getting along well with your wife. I shall offer you no advice on that subject.

Box 210.

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Remember Who You Are

Perennially, February brings to the nation a fitting reminder of two of its immortals through the observance of their birthday anniversaries. Washington, the Father of his country, and Lincoln, the great Emancipator, stand today as towering symbols of freedom in a world that holds freedom more and more cheaply. Some years ago when a new war was imminent, Carl Sandburg, a devoted student of Lincoln, addressed a confused, baffled, even somewhat bitter, graduating class at Harvard in these words: "Young gentlemen, I think you need the spirit of prayer and humility of Abraham Lincoln who, in 'the divided house' of his day, knew what to do because he knew who he was."[1]

There, truly, is something to ponder. The man who knows who he is will not give in, will not run away. Instead, he will know what to do — and do it. And so of this nation. In today's divided world, America in her unique position of world leadership needs fully to appreciate who she is and what has made her great. Then her future course will be clear. Looking backward upon her great heritage, she will go forward knowing what to do.

In this land of the free everybody is someone who counts, not merely something to be counted. Nevertheless, to keep aloft the concept of the dignity of the individual, the sacredness of personality, the infinite worth of the common man, grows increasingly more difficult and correspondingly more important.

It is a terrible thing for man to forget who he is, to lapse into a state of moral amnesia, as it were. Is he merely "a sick fly on a dizzy wheel," as H. L. Mencken would have it? If so, "then what is wrong with Communism or any other anthill philosophy?"[1] True, he is a child of earth, but with eternity planted in his heart. There is danger, therefore, not so much in thinking too highly of himself as in thinking too cheaply of himself. If people remembered who they are, how could they be guilty of the silly, shabby things they do to themselves and to others? Let every American honor Lincoln and Washington this month by remembering who he is and re-evaluating his concept of freedom in the light of their eyes.

American Medicine, likewise, in times like

these needs especially to remember its high calling and its noble heritage. Physicians with their prestige and their keen intellect have entered the battle to preserve not alone the American health but also the American way of life as set down by the founding fathers. In their brilliantly successful stand against socialized medicine and in their continuing endorsement of progressive legislative measures they have gone far beyond the realm of science and also far beyond the point of turning back. May they ever remember who they are and in that knowledge continue to scale new heights for professional, national and world betterment.

1. Hamilton, J. Wallace: Horns and Halos in Human Nature, Westwood, N. J., Fleming H. Revell Company, 1954.

The Malpractice Insurance Problem

III. The Insurance Companies and Malpractice Insurance

In the first two editorials of this series some of the causes and measures to be taken to prevent malpractice suits were discussed. This editorial concerns itself with the insurance companies and malpractice insurance.

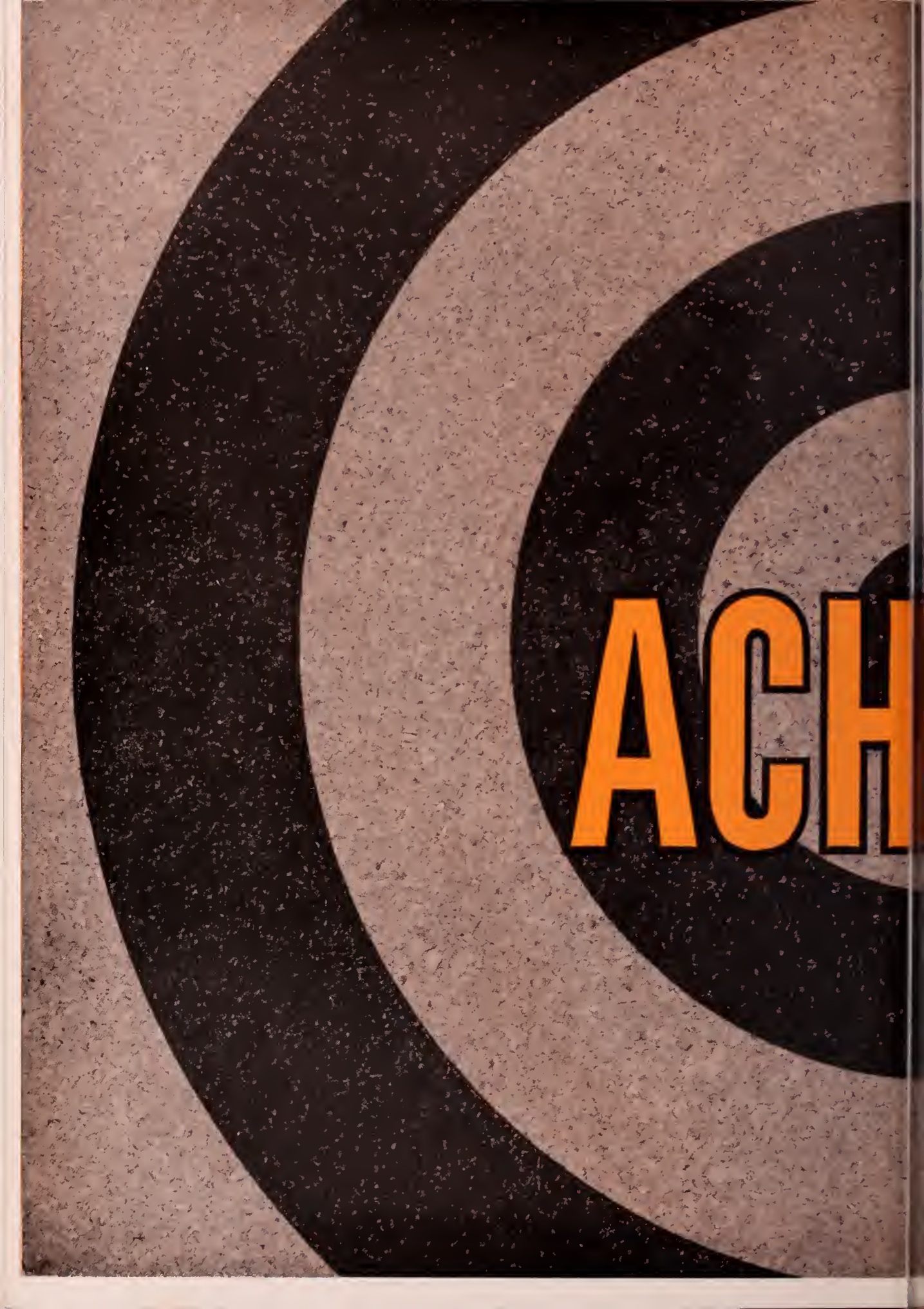
An understanding of any problem concerning malpractice insurance rates is predicated upon consideration of the attitude of the insurance company. Malpractice insurance has always been a minor side line with most insurance companies. It was written as a convenience to a physician client who might also be carrying other casualty and liability coverage with the same company, or it was written as a means of picking up some small change with little risk to the company. Because the risk was small, it could be written at a very low premium rate. A good comparison can be made with the "polio insurance" policies which are now being written and which for a $10 premium cover medical expenses arising from a case of poliomyelitis up to a maximum of $5,000. The $10 premiums which a major insurance company collects from such policies constitute a negligible part of the several million dollars collected annually in premiums; but the likelihood of a claim arising from such a policy is so remote that the insurance can be sold profitably at a very low rate. Now suppose that for several years in a row there were epidemics of poliomyelitis and that the number of claims multiplied by leaps and bounds. What would happen to the rates? The answer is obvious.

In the final analysis an insurance company is organized to render a service and, by so doing, to make a profit for its stockholders. It is not compelled to underwrite any kind of insurance and it is not likely to insure any risk unless it has a reasonable chance of making a profit. Because of their unfavorable experience in recent years many insurance companies are pulling out of the malpractice insurance field. In contrast to experience with claims in other types of casualty and liability insurance, the vast majority of malpractice claims occur from one to 20 years after the year in which the policy was written. Experience in New York State based on 170,000 policies issued over a 16 year period showed that only 21.4 per cent of the total claims made were filed within the first year after the issuance of the policy. At the end of six years 98.5 per cent of the claims had been made. This means that an insurance company is always working several years in retrospect. During a period in which the number of claims per doctor is on the increase, the underwriter is likely to take disturbing losses from underestimating the rate of increase of claims and, thus, charging too low premiums.

So much for the insurance companies' problems. The biggest criticism that the medical profession has of the insurance companies' activities in the malpractice insurance field is that they have done little or nothing to try to keep costs of this type of insurance low. Companies which have spent large sums of money in carrying on extensive programs in fire and accident prevention have shown no interest in trying to eradicate the causes of malpractice claims. Oftentimes, they have been anxious to make out-of-court settlements rather than bother with court trials. They apparently have kept most incomplete statistical records with respect to their loss experience and have been most reluctant to provide the Association with those statistics which they do have. Hearings which have been held recently before the Insurance Commission have revealed that the loss experience statistics which were being used as a basis for increasing rates are so inaccurate as to be practically valueless.

With the situation rapidly deteriorating, the Board of Governors of the Association decided to step into the picture. For the past several years the Secretary of the Association has been gathering information concerning the experience of other state medical associations with malpractice insurance. This has been a tedious under-

(Continued on page 652)


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(Continued from page 649)
taking because of the great dearth of factual material which exists on this subject. After studying all available material, the Committee on Medical Economics has presented to the Board of Governors a plan for improving the malpractice insurance experience in Florida. The Board of Governors has approved the plan, and it will be submitted to the House of Delegates for its consideration at the April 1955 meeting. This plan will be presented in the last article in this series, which will appear in next month's Journal.

Calling All Auxiliaries

Privately supported financial solvency for the nation's medical schools is a vital need of American Medicine today. The only alternative is federal subsidy. As mentioned editorially in the January Journal, the fund-raising campaign of the American Medical Education Foundation for 1955, to promote the growing movement to come to the aid of the hard-pressed medical schools, is already underway. Last year physicians subscribed more than $1,000,000 for this purpose. This year's goal is $2,000,000.

Pledged to give wholehearted support to this program, Auxiliary members throughout the country are standing shoulder to shoulder with their doctor-husbands in an effort to help them reach this goal. Their donation to the fund in 1954 exceeded $50,000. With each individual member assuming responsibility for a share in this great project, they expect to make a much larger contribution this year. Certainly, they could find no worthier cause to support and none offering more of a challenge to their endeavors.

The Woman's Auxiliary to the Florida Medical Association is in the forefront of the 44 state auxiliaries working to promote this program. It is eager to have a part in enabling America to have the best trained medical men in the world and to keep the United States the healthiest land in the world. Its members are proud to be among those workers of whom President Eisenhower recently said: "I don't know of any group that is doing more necessary and worthwhile work than making certain that our medical schools have ample funds from private sources to keep running, because this is one profession we don't want to get under the dead hand of bureaucracy." While he was president of Columbia University, Mr. Eisenhower was largely responsible for initiating the nationwide fund-raising movement in behalf of the medical schools, of which the American Medical Education Foundation is an important part.

The Auxiliary officers are urging all of the 21 component county auxiliaries in Florida to plan early for maximum participation in this campaign. Mrs. Richard F. Stover, President, stresses the importance of each and every member of all the auxiliaries taking an active part in helping to attain the Foundation's 1955 goal. The Auxiliary's Chairman for American Medical Education Foundation, Mrs. Lucien Y. Dyrenforth, invites inquiry about the many fund-raising suggestions she has to offer and points out that the phenomenal success of some of the auxiliaries should inspire full cooperation and renewed endeavor on the part of all to give Florida a 100 per cent record.

It is particularly important that funds be remitted to the state AMEF chairman rather than to national headquarters in order to insure proper credit to the Auxiliary. Checks should be made payable to AMEF-Auxiliary Fund, and they may be earmarked for any of the 80 accredited medical schools of the country. Send them to Mrs. Lucien Y. Dyrenforth, Chairman, American Medical Education Foundation, 3885 St. Johns Ave., Jacksonville 5.

The Florida Medical Association is proud of its Auxiliary and looks to it to set the pace in 1955 for the best contribution by far that the Association and the Auxiliary have ever made to this cause. To have a part in keeping the nation's medical schools free and of highest standard is both a duty and a privilege.

Public Relations Manual

A working manual on medical public relations is now available to interested members of the Florida Medical Association. Entitled "County Medical Public Relations Manual," this handbook is designed especially to aid county medical societies in establishing and maintaining a basic Public Relations Program. It has been prepared by the Department of Public Relations of the American Medical Association and represents years of research into successful public relations programs throughout the county.

In attractive loose leaf, indexed format with appropriate illustrations, the Manual contains general public relations information, explains how to organize for public relations action, and outlines many projects to promote favorable public response at the county society level. It offers a year

round plan based on activities already proved successful in the field. Altogether practical in its approach, it not only reports what other societies have done, but also provides an authoritative guide for the public relations chairman, showing what his society can do and relating how this constructive program can be carried out.

Set forth in terms of organization and promotion are eight fundamental programs described as the "basic eight" plan. They relate to Emergency Call Systems, Mediation Committees, Press Relations, Speakers Bureaus, Society Member Indoctrination, Provision of Medical Care For All, Public Service Activities, and Citizenship Activities. For societies having this comprehensive plan now in successful operation the Manual offers stimulation and reinforcement of present activities with its many ideas, suggestions and supplementary projects.

Because of the value and limited supply of this handbook, it will be sent only to members of the Association who request it. Last month a letter, with order form enclosed, was sent by Dr. Edward Jelks, Liaison for Public Relations, Board of Governors, to the president, secretary and public relations chairman of all county medical societies. To these officers the Manual will be of particular worth, and they are urged not to delay in sending in their order. Other members of the Association also will find this handbook unequaled as a source of information on public relations and may request a copy if sufficiently interested. The Manual is available through the Association's Bureau of Public Relations.

Southern Physician Named As 1954 General Practitioner of the Year

At the recent annual Clinical Meeting of the American Medical Association in Miami, Dr. Karl B. Pace of Greenville, N. C., was the recipient of the annual General Practitioner's award, consisting of a gold medal and a citation. This typical family doctor of 1954 received his medical training at Jefferson Medical College in Philadelphia and returned to his native state in 1916 to engage in the general practice of medicine in Greenville for 40 years except for his military service in World War I.

Throughout his long career Dr. Pace has devoted himself to aiding his fellow men and to the betterment of his profession. His is a phenomenal record of leadership in the medical organizations of his state, and despite the demands of his heavy practice he has been outstanding in civic and religious activities as well. Never, though, according to a colleague, has he "become too busy to stop and listen to people's troubles and to try to help in solving their problems through sympathetic counsel, encouragement and financial aid." Here then in this exemplary physician is the perfect example of the synthesis of the art and science of medicine in action, with the patient in proper focus as a person.

In an interview with the lay press in Miami, Dr. Pace singled out "nerves and tension" as a major cause of American ill health today. "Forty years ago," he observed, "only about 10 per cent of my patients had some psychosomatic or emotional trouble. Now it's easily 60 per cent. Physically there's little or nothing wrong with them. The doctor has to be a family counselor to learn the psychological cause of their aches and pains." He prescribed these antidotes for tension and worry:

"Live each day as it comes — don't worry about next week."

"Learn to live instead of trying to get rich."

"Never stay mad."

"Start out by liking everyone you meet."

"Take a siesta after lunch, to help you relax."

Dr. Pace finds that a doctor avoids wear and tear on himself if he considers every patient as a good opportunity for a little visit and a friendly chat, as well as a scientific consultation. That helps both the doctor and patient to relax. Fond of fishing, he does most of his fishing in his office — talking fishing.

Eight physicians now have been the recipients of the annual General Practitioner's award. Dr. Pace is the fourth Southerner to receive this signal honor. The other three are the late William L. Pressly of Due West, S. C., John M. Travers of Jacksonville, Texas, and Joseph I. Greenwell of New Haven, Ky.

EIGHTY-FIRST ANNUAL MEETING

FLORIDA MEDICAL ASSOCIATION

ST. PETERSBURG

APRIL 3-6, 1955

Vocational Rehabilitation Expanded Program Regulations

The expanded vocational rehabilitation program passed by the 83rd Congress (P. L. 565) envisions 200,000 rehabilitations a year by 1959 as against the current rate of 60,000. Regulations spelling out details of this program have been issued by the Department of Health, Education, and Welfare. They cover 11 pages of the Federal Register of December 2, 1954, and, in general, follow the same language as in the law.

To insure no duplication of rehabilitation facilities, these regulations require states to coordinate their vocational rehabilitation activities with those of the expanded Hill-Burton program, which provides for grants to states for rehabilitation centers as well as for hospitals, clinics and nursing homes. The last Congress voted $4 million for these.

Of particular interest to physicians is a section of the regulations which provides that any rehabilitation facility providing an integrated program of "medical, psychological, social and vocational evaluation and services" must be under the formal supervision of persons licensed to practice medicine and surgery in the state. This is the first time that this provision has been written into law.

Attention was directed recently to the government's role in providing employment for the handicapped when a certificate of distinguished service was awarded Dr. Verne K. Harvey, medical director for the federal Civil Service Commission, by the President's Committee on Employment of the Physically Handicapped for his work in helping the handicapped obtain government positions. In the war years 1942-1945, government work was obtained by 69,842 disabled persons. Since 1945 placements have been more difficult than in wartime, but commission estimates for this period indicate that 82,750 have found employment in government.

Addressing the National Society for Crippled Children and Adults in Boston recently, former HEW Under Secretary Nelson Rockefeller said: "We are on the threshold of a new era in rehabilitation — an era of unprecedented cooperation between public and voluntary agencies, and an era of unparallelled achievement in men's struggle against disability."

Health Fair for the Public A Miami First

As the Clinical Meeting of the American Medical Association came to a close last December 2 in Miami, a Health Fair for the Public opened in that city's Bayfront auditorium. The four day event was continued from Thursday through Sunday and marked the first time such a project had been undertaken in connection with the AMA Clinical Meeting. The Fair featured more than 80 exhibits and was conducted under the auspices of the Dade County Medical Association in collaboration with the American Medical Association and the Florida Medical Association.

The Health Fair for the Public was presented primarily for educational purposes. A wealth of exceptional and extremely interesting material was offered by many of the nation's leading health agencies, museums and institutions. Visitors had a unique opportunity to gain better knowledge of health facts and progress by viewing the exhibits and film presentations. They were invited to browse around, ask questions of the experts, have tests made and check their knowledge of the various subjects.

The 18 subjects covered were: Accidents; Nutrition; General; Diseases; Research; Blood; Sight, Hearing and Speech; Economics; Growth; Physical Therapy; Narcotics; Mental Health; The Body; Alcoholism; Heart; Cancer; Teeth; and Tuberculosis. Some of the finest films ever assembled on one health program comprised the daily motion picture program, which drew capacity crowds at every showing. Their titles indicate their practical value and appropriate selection: Losing to Win (Obesity); Come Clean (Dental Health); America's Untapped Assets (Employment of Handicapped); Alcoholism; The Unsuspected (Tuberculosis); First Aid on the Spot; Here's Health the American Way; Be Your Age (Heart Disease); Lady with a Lamp (Nurse Recruitment); Training of Seeing Eye Dogs; and Traitor Within (Cancer).

An outstanding feature of this event was tours for school children, 6,300 of whom visited the Fair on a schedule basis with their teachers. The excellent adult response was reflected in the total attendance, which was 43,378. Such an attraction for the public in association with the annual AMA Clinical Meeting had been contemplated for some years. The success in Miami of this first venture sets the pattern for future fairs each winter in the wake of this gathering. So favorable was the gen-

eral impression that the Association of State and Territorial Health Officers at their annual meeting shortly afterward recommended that "the American Medical Association and constituent state and county societies should continue sponsorship of health fairs such as the one held recently at the clinical session in Miami as an excellent means for carrying out effective health education."

Gerontological Society Meeting Held at University of Florida

The Seventh Annual Scientific Meeting of the Gerontological Society, Inc., was held in Gainesville on Dec. 28-30, 1954, in cooperation with the Fifth Annual Southern Conference of the Institute of Gerontology of the University of Florida. The widely diversified program covered highly scientific research as well as clinical observations in the four sections, namely, Biological Sciences, Psychological and Social Sciences, Clinical Medicine, and Social Work and Administration. Eminent essayists from throughout the country presented the papers. At the annual dinner on Wednesday night, December 29, President A. J. Carlson, a faculty member of the University of Chicago, made his presidential address. Dr. E. L. Bortz, distinguished Philadelphia physician, was chairman of the program committee, and Dr. R. W. Kleemeier of Orange Park was chairman of the local arrangements committee.

"Recent Advances in Medical Handling of the Geriatric Patient" was the subject of a panel discussion presented at the general meeting on Wednesday night with Dr. Turner Z. Cason of Jacksonville serving as chairman. Participating were four Florida physicians, all of St. Petersburg, Dr. Norval M. Marr, discussing "Hypertension and Arteriosclerosis," Dr. Clyde O. Anderson, discussing "Important Facts Concerning Diabetes Mellitus Among the Aged," Dr. Richard Reeser Jr., discussing "Some Observations in the Management of the Aging Cardiac," and Dr. N. Worth Gable, discussing "Vision and Hearing of the Aged." The fifth participant was Dr. William B. Kountz of St. Louis, Director of the Section of Gerontology and Assistant Professor of Medicine, Washington University School of Medicine, whose subject was "Metabolism in the Aged."

There were two sessions of the Section on Clinical Medicine, both also held on Wednesday. Dr. Cason presided at the morning session and Dr. Kountz, program chairman for the section, presided at the afternoon session. Among the impressive list of papers presented by distinguished speakers from various sections of the country were three by Florida physicians. Dr. Louis L. Amato of Fort Lauderdale spoke on "The Practice of Geriatrics," and a paper by Dr. George R. Crisler of Winter Park entitled "Intermittent Claudication Treated with Ultrafaradism" and one by Dr. Sidney Storch of Jacksonville entitled "The Ballistocardiogram in the Aged" were read by title.

In view of Florida's peculiar problems in dealing with aged persons, the formation of a state group for the study of the problems of old age got underway during the meeting. No name was selected for the group. A planning committee was named to undertake the preliminaries of organization, and this committee later will call a formal meeting of interested persons for the purpose of electing officers and adopting a charter. The members of this committee are: Dr. Irving Webber, University of Florida, Gainesville; Dr. Amato; Dr. Sidney Entman, Jacksonville; Dr. Robert E. Rothermel, St. Petersburg; and Dr. Samuel Gertman, Miami. The purposes of the group, to be adopted in the charter, include "the encouraging of gerontological research in Florida, the exchange of technical information, the recommendation of legislation, the stimulation of community action, education of the public to the problems of old age, and the collection and dissemination of information."

Eighty-First Annual Meeting

FLORIDA MEDICAL ASSOCIATION

St. Petersburg April 3-6, 1955

Graduate Medical Education
Cardiovascular Diseases Seminar
February 17-18

A Seminar on Cardiovascular Diseases will be held at the Duval Medical Center in Jacksonville on Thursday and Friday, February 17 and 18, 1955. This Seminar is sponsored by the Duval District Heart Association in cooperation with the Florida Medical Association, the Florida State Board of Health, and the Department of Medicine of the Graduate School of the University of Florida. The registration fee for the course is $10.00.

Four distinguished lecturers comprise the faculty, Dr. George T. Harrell, Dean and Professor of Medicine at the College of Medicine of the University of Florida in Gainesville, will open the meeting on Thursday morning with a lecture on "Thyrotoxic Heart Disease" and present the subject of "Myxedema Heart Disease" on Friday. He will be followed on Thursday by Dr. James W. Culbertson, Associate Professor of Internal Medicine at the State University of Iowa College of Medicine in Iowa City, Iowa, whose subject at that time and on the following day will be "Systemic Arterial Hypertension."

Dr. Henry T. Bahnson, Associate Professor of Surgery at the Johns Hopkins University School of Medicine in Baltimore, will lecture twice on Thursday, his subjects being "Surgery of the Aorta" and "Recent Advances in Cardiovascular Surgery." The fourth faculty member is Dr. Samuel P. Martin, Associate Professor of Medicine and Bacteriology at Duke University School of Medicine in Durham, N. C. He will lecture on "Bacterial Endocarditis" on Thursday, and on Friday his subject will be "Rheumatic Heart Disease."

The lectures will begin at 9:30 each morning. A Clinicopathologic Conference will be featured on Thursday afternoon, and on Friday afternoon a clinical conference will be followed by a panel discussion on "Management of the Cardiovascular Patient," with all four members of the faculty participating.

Programs were mailed to all physicians in the state late last month. The program schedule follows.

PROGRAM FOR SEMINAR ON CARDIOVASCULAR DISEASES

February 17-18, 1955
Duval Medical Center
Jacksonville

FEBRUARY 17
THURSDAY:

8:30- 9:30	Registration
9:30-10:10	Thyrotoxic Heart Disease Dr. George T. Harrell In thyrotoxicosis the heart rate and cardiac output are increased. Auricular fibrillation may be the most prominent physical sign, particularly in older patients. The increase in the rate of all metabolic functions is reflected in intracellular stores of essential foodstuffs, including minerals and vitamins. Radioactive iodine is the treatment of choice in smooth hyperplasia, but surgery may be necessary in toxic nodular goiter.
10:10-10:50	Clinical Features and Physiopathology of Systemic Arterial Hypertension Dr. James W. Culbertson Diverse clinical manifestations will be reviewed in order to focus attention on the physiopathology of essential hypertension. Finally, special attention will be given to pheochromocytoma.
10:50-11:00	Recess

11:00-11:40 Surgery of the Aorta
Dr. Henry T. Bahnson

Experience gained with coarctation and other vascular diseases has opened the way for a direct surgical attack upon aortic aneurysms and upon aortic thrombosis. A discussion of etiology, diagnosis and surgical treatment of these conditions will be presented.

11:40-12:30 Bacterial Endocarditis
Dr. Samuel P. Martin

12:30- 2:00 Lunch

2:00- 4:00 Clinicopathologic Conference

4:00- 4:15 Recess

4:15- 5:00 Recent Advances in Cardiovascular Surgery
Dr. Henry T. Bahnson

Recent contributions to surgical technic and management of the patient with cardiovascular disease will be discussed. The treatment of auricular and ventricular septal defect, the use of mechanical aids and of hypothermia for open cardiac surgery, and a consideration of the current status of the treatment of rheumatic heart disease will be included in the discussion.

FEBRUARY 18
FRIDAY:

9:00- 9:40 Rheumatic Heart Disease
Dr. Samuel P. Martin

9:40-10:10 Management of Systemic Arterial Hypertension
Dr. James W. Culbertson

Various methods of current therapy will be discussed: general measures, weight reduction, sodium and protein dietary restriction, rauwolfia, veratrum, hydralazine, pentolinium, hexamethonium, sympathectomy, adrenalectomy, nephrectomy, and excision of tumors.

10:10-10:20 Recess

10:20-11:00 Rheumatic Heart Disease
Dr. Samuel P. Martin

11:00-11:40 Myxedema Heart Disease
Dr. George T. Harrell

In myxedema the rate and amplitude of the heart beat are diminished. The permeability of capillary and cellular membranes is increased to sodium ions so that the function of myocardial and other cells is decreased. The metabolism of foods is impaired and the accumulation of lipids in the blood leads to early atherosclerosis. Replacement therapy must begin cautiously because of the complication of coronary insufficiency.

11:40-12:30 Question and Answer Period

12:30- 2:00 Lunch

2:00- 3:30 Clinical Conference

3:30- 5:00 Panel: Management of the Cardiovascular Patient
Drs. Harrell, Culbertson, Bahnson, Martin

Relic of Early Days

From its old files the Ocala Star-Banner recently published a medical item reminiscent of the good old days. It described the medical case of Dr. T. P. Gary, who came to Ocala in the 1850s and practiced medicine there for about 30 years. Apparently handmade and of excellent workmanship, it measured 11 by 14 x 7½ inches. The corners were dovetailed, and the velvet lining was designed to cushion the square glass bottles and stoppers with which it was filled. The case contained 20 of these bottles, some still filled with medicine. There was an extra compartment and small drawer which the doctor could lift out. Among the labels still readable were "aqua ammonia, cathartic, brandy, Flu. Ext., Bucha, pain killer, sweet spirits of nitre, paregoric and spirits of camphor."

The case was the property of Dr. Eaton G. Lindner at the time the undated item out of the past was written. Perhaps it is still in his possession, bearing mute testimony to the trail blazed by a pioneer physician of Florida a century ago. Were it articulate, what an interesting chapter it doubtless could add to the state's medical history.

OTHERS ARE SAYING

Legal Medicine — The New Approach*

A grave misconception now current in the medical profession at large, and more particularly among pathologists, is that the Medical Examiner System is designed for the express purpose of replacing, in all jurisdictions, the old coroner system.

The coroner's jurisdiction is always predicated on the probability or possibility of foul play. The modern progression of knowledge and methodology has rendered the office of coroner obsolete. Indeed, if the medical problems dealing solely with those of foul play were the only ones concerned, it is questionable whether it would be practical to set up a system of trained personnel for the relatively few obscure cases of violent death that require expert medical review.

The modern medical examiner is not concerned primarily with the medical fact-finding functions of the old coroner. What must be recognized is that because of the vast social and economic advances that have been made, it has become necessary for the State to establish a new officer whose function it is to inquire into a great variety of deaths; the vast majority of these are not associated with foul play. It is essential for the State to provide a system for deciding whether on purely medical grounds a decedent's family has a claim against private funds, i.e., funds held by the insurance companies in trust for their policy holders. As a corollary, it is necessary to decide whether both State and private funds are to be protected against raiding by claimants.

It is important to ascertain whether decedents, who have died from obscure causes, have in fact died from infections or contagious diseases that constitute a menace to the public health. It is important that a large number of deaths be investigated to ascertain trends of disease in order that Society may take the proper steps to solve problems associated with such diseases. Moreover, it becomes increasingly important to Society to know precisely the cause of death, certainly in obscure situations, and ideally in every case in order that a clear picture of the deficiencies in the Nation's health be adequately known and studied.

*Geoffrey T. Mann. Program International Congress of Clinical Pathology, International Conference of Geographic Pathology, and International Meeting of International Association of Medical Museums, September 6-11, 1954, Washington, D. C. page 96.
Am. J. Cl. Path. 24: (Aug.) 1954.

—Illinois Medical Journal, October 1954

Hazards in Sports

Considering that millions of our people participate in competitive sports, it is not surprising that fatalities occur and that many contestants are more or less seriously injured.

As there is no way of knowing the exact number who take part in athletics, an over-all estimate of fatalities and injuries is not available. However, the *Statistical Bulletin of the Metropolitan Life Insurance Company* for June, 1954, points up some interesting facts. For example, the *Bulletin* states that among several million males between the ages of 10 and 29 years insured by the Metropolitan Life Insurance Company, there were only 11 deaths resulting from competitive sports in the years 1951-1952. In the Company's experience, this is less than one in every 300 accidental fatalities of all types.

The infrequency of fatal injuries in sports is also shown by the experience in New York City, where in three decades there were approximatly 100 deaths, an average of only three a year. Baseball, football, and boxing, in this order were responsible for four fifths of the deaths.

Nationally, the figures available are not so comforting. In the period 1949-1953 football accounted for 94 deaths. Listed as causes of 65 of these fatalities were tackling, blocking, and piling up. The remaining 29 were attributed to infection, heart failure, pneumonia, and other causes resulting from the game.

A further breakdown of football deaths, showing their source, follows:

	Direct cause of death	Indict cause of death
College	4	4
High School	37	12
Professional and semiprofessional	9	3
Sandlot	15	10
Total	65	29

Source of data: Dr. Floyd R. Eastwood, Chairman, Committee on Injuries and Fatalities, American Football Coaches Association.

Boxing during the same period claimed 29 participants; 17 of these were amateur fighters and 12 were professionals. The *Bulletin* points out that the deaths among professional boxers have decreased in recent years, due largely to efforts of the state boxing authorities to make the sport safer.

On the basis of the Metropolitan's experience, it is probable that baseball accounted for more fatal injuries than any other sport. This conclusion is arrived at because of the wide popularity of the game and the large numbers participating. Interestingly, there have been no fatalities among the approximately 400 players in the major leagues since 1920.

As millions of participants know, golf also has its hazards. The *Bulletin* reports three deaths among Metropolitan policyholders in 1951-1952, one player being fatally injured when hit by a ball in flight, another was struck by a club swung by another player, and the third was struck by lightning while on the course.

It will undoubtedly come as a surprise to many readers that in professional hockey, certainly one of the most rugged of professional sports, there has not been a death since 1937. Neither is there record of a death in professional basketball, while in soccer there has been only one death in four decades. There are no deaths attributed to skating, or roller derby contests, in which some 100 skaters compete each year, since their inception in 1935.

—*Medical Annals of the District of Columbia, October 1954*

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. Benjamin J. Philips Jr. of Jacksonville announce the arrival in their home of a daughter, Carol Lynn.

Dr. and Mrs. Matthew E. Morrow Jr. of Jacksonville announce the birth of a son, Peyton Jefferson, on Dec. 30, 1954.

Dr. and Mrs. Bernard L. N. Morgan of Jacksonville announce the birth of a son, Clive Newlands, on Jan. 3, 1955.

Dr. and Mrs. Benjamin H. Sullivan of St. Petersburg announce the birth of a daughter, Anne Marie, on Jan. 10, 1955.

Marriages

Dr. Fred E. Brammer of Dania and Mrs. Goldie Nickum of Fort Lauderdale were married on Dec. 20, 1954, in Fort Lauderdale.

Deaths — Members

Frobisher, Hamilton B., Miami ..... Nov. 10, 1954
Hardman, James C., Miami ..... Nov. 27, 1954
Glatzau, Lewis W., Daytona Beach ..... Dec. 14, 1954
Speers, Dorothy J., Titusville ..... Jan. 4, 1955

Deaths — Other Doctors

Friedrich, Martin, Brooklyn ..... Oct. 18, 1954
Rodriguez-Basso, Enrique, Key West ..... Dec. 14, 1954
Langan, Paul C., Miami ..... Jan. 4, 1955

EIGHTY-FIRST ANNUAL MEETING
FLORIDA MEDICAL ASSOCIATION
ST. PETERSBURG
APRIL 3-6, 1955

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Brashear, Billy, Gainesville

Coffer, Robert H. Jr., Tampa

Crago, John A., Gainesville

Cousar, James E. III, Jacksonville

Dean, William J., St. Petersburg

Duckett, Howard C. Jr., Jacksonville

Ekwall, Merton L., Jacksonville

Fort, Chester A. Jr., Jacksonville

Fox, Earl R., St. Petersburg

Gilliland, Charles H., Gainesville

Goodgame, John T., Clearwater

Gouaux, James L., St. Petersburg

Harrell, George T. Jr., Gainesville

Hendrick, James W., Jacksonville

Johnson, Charles A. Jr., Clearwater

Matthews, Joseph G., Orlando

Merchant, John P. Jr., Orlando

Mullins, S. Delan Jr., Clearwater

Newman, Abe L., North Miami

Overbey, David T. Jr., St. Petersburg

Pacetti, William A. Jr., Coral Gables

Ploss, William R., Key West

Stuart, Jack F., Miami

Ward, Robert B., Miami

Wright, John E., Miami

Medical Officers Returned

Dr. Ralph Robbins, who entered military service on Nov. 14, 1952, was released from active duty on Nov. 14, 1954 with the rank of captain, USAF. His address is 1100 Drexel Ave., Miami Beach.

STATE NEWS ITEMS

Dr. Lorenzo L. Parks of Jacksonville gave a talk on polio before a district institute for volunteer polio workers in Lake City in November.

Drs. Alfred G. Levin and Raymond E. Parks of Miami and Theodore M. Berman of Miami Beach attended a continuation course in Bone Roentgenology at the University of Minnesota, Minneapolis, Nov. 8-13, 1954.

Dr. Sidney Stillman of Jacksonville has been appointed to the State Board of Medical Examiners by Acting Governor Charley E. Johns.

The Miami Pediatric Society Quarterly Meeting was held on December 15. The program included a film on "Sex Education."

Dr. Lucien Y. Dyrenforth of Jacksonville attended a Pathology Seminar in Boston in November.

Dr. John H. Mitchell of Jacksonville has again been elected president of the Board of Directors of the Baptist Home for Children in which capacity he served from 1937 to 1950.

The facilities of the Library of the Florida State Board of Health are available to all members of the Florida Medical Association, as well as other interested persons.

The Library was founded in 1932 to serve Florida's physicians, as well as its public health personnel, and continues operation with this dual purpose. Four hundred and twenty-five periodicals are currently received, among which are the basic medical journals. Lists of these periodicals are available upon request.

If you are writing a paper or making a speech, the librarian will be glad to compile a list of references on the subject and lend any of the material which is available. Loans of both books and journals are for one month from the date mailed.

Address all requests to the Librarian, Florida State Board of Health Library, P.O. Box 210, Jacksonville 1.

Dr. Edward W. Ford of Crescent City was honored on December 1 by the Rotary Club, the Woodmen of the World and other groups in Crescent City for his many years of service to the community. Dr. Ford, who has practiced medicine for 63 years, was presented a plaque and citation at a dinner in his honor.

Dr. Roslyn Skyer of West Palm Beach spoke on the work of the Hadassah Medical Organization in the new immigrant villages in Israel at a meeting of the Palm Beach County Chapter of Hadassah on December 8.

Dr. Robert E. Rothermel of St. Petersburg was moderator of a forum on "Gerontology — America's New Problem," at the Gulf Coast Health Conference held in that city in December.

Mrs. Richard F. Stover of Miami, president of the Woman's Auxiliary to the Florida Medical Association, attended meetings of the Brevard, Hillsborough and Polk Auxiliaries in January, and will attend a meeting of the Escambia Auxiliary in February.

Any physician desiring to donate duplicate journals or back issues, text books or monographs, to the College of Medicine of the J. Hillis Miller Health Center at the University of Florida, please correspond with Mr. Fred Bryant, Librarian for the Health Center, University of Florida, Gainesville.

Dr. Iva C. Youmans of Miami has been selected the Medical Woman of the Year of Branch Thirty-Three of the American Medical Women's Association.

The Twenty-Eighth Annual Spring Congress of the Gill Memorial Eye, Ear, and Throat Hospital will be held April 4-9, 1955, in Roanoke, Va. Courses in Otolaryngology will be held April 4 through 6, and those in Ophthalmology, April 7 through 9. Registration fee is $20. For further information write E. G. Gill, M.D., Box 1789, Roanoke, Va.

Dr. George D. Lilly of Miami was elected treasurer of the Southern Surgical Association at the recent annual meeting in Hollywood.

Dr. Frank G. Slaughter of Jacksonville spoke on "History Can Be Fun" before the November meeting of the Lake Shore Junior High School's Dads' Club.

Dr. Slaughter was guest speaker at one of the "Meet the Author" series of meetings held at Florida State University in Tallahassee recently.

Dr. John H. Kay of Pensacola has been appointed a member of the Committee on Professional Service for the Florida Division, American Cancer Society. He has also been named district director, Florida Division, American Cancer Society, of the units within the areas of Bay, Gulf, Franklin and Calhoun counties.

Dr. Ray O. Edwards Jr. of Jacksonville attended an Institute on Mental Deficiency sponsored by the American Association on Mental Deficiency in Nashville in November.

Dr. Jack Q. Cleveland of Coral Gables, State Chairman for the American Medical Education Foundation, attended the Fourth Annual Meeting of the AMEF state chairmen at the Sheraton Hotel in Chicago on January 23. This meeting served as the kick-off for the 1955 fund-raising campaign.

Dr. Chas. McC. Gray of Tampa was installed as 2nd vice president of the Radiological Society of North America at the Fortieth Annual Meeting in Los Angeles, Dec. 5-10, 1954.

Dr. William H. McCullagh of Jacksonville spoke on "The Personalities of Law Violators" at an in-training institute for Florida Parole Commission officers in Jacksonville in November.

Drs. Evison I. Carefoot and Charles D. Cooksey of Jacksonville have been named to the District 6 Welfare Board.

Dr. Phillip W. Horn and Dr. Bernard J. McCloskey of Jacksonville took a postgraduate course in "Newer Developments in Cardiovascular Diseases" held under the auspices of the American College of Physicians in New York in October.

Physicians who pilot airplanes are forming an organization of flying physicians. This will be a national organization of doctor pilots with chapters in each state. Purposes of the organization will be educational, scientific and social.

The Florida Chapter is anxious to secure a list of all Florida physicians who are active pilots. As yet there are no obligations. If you are an M.D. and a licensed aircraft pilot, please send your name to Herbert Eichert, M.D., Chairman of Florida Chapter, 30 S. E. 8th St., Miami.

The Florida Trudeau Society will hold its annual meeting in conjunction with the Florida Tuberculosis and Health Association's annual conference, May 12-14, 1955, at the McAllister Hotel, Miami.

A technical program will be presented by the Trudeau Society, according to Dr. Lawrence C. Manni, Tallahassee, president. Other Trudeau officers are Dr. Harold W. Johnston, Orlando, vice president, and Dr. Simon D. Doff, Jacksonville, secretary.

The Florida Trudeau Society, which is the medical branch of the Florida Tuberculosis and Health Association, has a membership of more than 100 Florida physicians.

Dr. Homer L. Pearson Jr. of Miami was among a group of 13 members of the A.M.A. named to a committee to make a year-long study of the various health plans in the United States. The appointment was made at the recent Clinical Session held in Miami.

Dr. Turner Z. Cason of Jacksonville was principal speaker at the first state meeting of the Florida Medical Secretaries and Assistants Association held in Jacksonville in November.

Dr. Gary E. Turner of Jacksonville talked on "The Psychiatrist's View of School Guidance Activities" at a guidance conference sponsored by the Jacksonville Junior College on December 7.

Drs. James C. Lanier and Frank G. Slaughter of Jacksonville took part in a forum on censorship of comic books at Riverside Baptist Church in that city in November.

Dr. Louis M. Orr of Orlando has been appointed by the A.M.A. Board of Trustees to a joint A.M.A.-American Legion committee for the study of veterans' hospitalization.

Dr. Rothwell C. Polk of Jacksonville recently spoke on "Cancer of the Breast" before a meeting of the Arlington Junior Woman's Club. The talk followed the showing of the film, "Self Examination of the Breast," presented by the American Cancer Society.

Dr. Robert E. Zellner of Orlando spoke on health at the regular January meeting of the Central Florida Association of Accident and Health Underwriters.

Dr. Bernard D. Ross of Miami spoke on January 5 before the Flamingo Chapter of the National Children's Cardiac Hospital.

Dr. Clarence L. Brumback of West Palm Beach spoke on the "Public Health Story in Palm Beach County" on January 12 at a meeting sponsored by the Palm Beach County Visiting Nurse Association.

Dr. Melvin Wolkowsky of Miami Beach spoke on the heart at a meeting of the Dade Chapter, National Children's Cardiac Hospital, January 12.

Dr. Wesley W. Wilson of Tampa spoke on skin cancer at a January meeting of the Hillsborough County Republican Club.

Dr. Harold B. Canning of Wewahitchka was guest speaker at a meeting of the Blountstown P.-T.A. on January 11.

Dr. Richard G. Skinner Jr. of Jacksonville spoke before a parents' meeting of the United Cerebral Palsy Society in November. His subject was the work of the newly formed clinic.

Dr. Irvine K. Furman of Jacksonville took part in a panel discussion on moral and spiritual values in the home and community at the October meeting of the Hyde Park P.-T.A.

Dr. Mortimer D. Abrashkin of Miami Beach spoke on "Orthopedic Injuries" and Dr. W. Tracy Haverfield of Miami, on "Injuries to the Nervous System" at the annual legal institute held in conjunction with the annual meeting of the Jacksonville Bar Association on December 9.

Dr. Warren W. Quillian of Coral Gables has been appointed to the Dade County Health Advisory Board.

Dr. Godfrey L. Beaumont of Sebring has been hired by the State Board of Health as director of the field advisory staff in the central office at Jacksonville.

Dr. Bernard L. N. Morgan of Jacksonville was guest speaker at the annual meeting of the Jamaica Branch of the British Medical Association at Kingston, Jamaica, in December 1954. The subject of his paper was "Reconstructive Surgery."

Dr. Carl C. Mendoza of Jacksonville was recently presented a shotgun by the Lee High School football team. Dr. Mendoza served as team physician.

Dr. Ivan Isaacs of Jacksonville recently attended a course in "Pathology and Roentgen Diagnosis" at the University of Minnesota and visited several clinics in St. Louis.

Dr. Kenneth S. Whitmer of Miami spoke before the Parents of the Blind, Inc., of South Florida on December 15.

Drs. Irwin S. Leinbach and Robert E. Rothermel of St. Petersburg took part in a panel discussion on child guidance sponsored by the North Shore P.-T.A. at the Soreno Hotel on November 29.

Dr. Paul N. Unger of Miami Beach spoke before the student body of St. Patrick's School on December 3.

Dr. Chas. J. Collins of Orlando led the discussion following a film showing at a meeting of the Orange County Unit, Florida Division, of the American Cancer Society, held December 6.

Dr. George C. Hopkins of St. Augustine led the March of Dimes Drive in that city in January.

The annual meeting of the Southeastern Allergy Association will be held at the Orange Court Hotel in Orlando, March 25-26, 1955. The theme of this year's meeting is "Allergy and Its Relation to Industrial Medicine." The meeting will feature prominent speakers and interesting papers.

Anyone having a paper they wish to present should write immediately to Dr. Ben Miller, 1433 Gregg St., Columbia, S. C.

Dr. Edward Jelks of Jacksonville attended the meeting of the Polk County Medical Association on January 12 in Winter Haven.

Dr. Isabel Roberts of Melbourne was guest of honor at the December 27 meeting of the Melbourne-Eau Gallie Business and Professional Woman's Club.

Dr. Mozart A. Lischkoff of Pensacola talked on the history of the Escambia General Hospital at a meeting of the Escambia County Medical Auxiliary in November.

Dr. Clarence M. Sharp of Jacksonville was guest speaker at a program on welfare agencies and their function presented to the Women's Division of the Miami Chamber of Commerce on November 30.

COMPONENT SOCIETY NOTES

Alachua

New officers of the Alachua County Medical Society are Drs. Edwin H. Andrews, president; Albert G. Love IV, president-elect; I. Irving Weintraub, vice president; and Henry S. Blank, secretary-treasurer, all of Gainesville.

Bay

At the regular monthly meeting of the Bay County Medical Society, officers for 1955 were elected as follows: Dr. William F. Humphreys Jr., president; Dr. William C. Fontaine, vice president; Dr. Roderick C. Webb, secretary; and Dr. Jack Corbitt, treasurer, all of Panama City.

Brevard

Officers elected to serve the Brevard County Medical Society in 1955 are Drs. Lee Rogers Jr., president, Cocoa; Arthur C. Tedford, vice president, Melbourne; and Charles E. Russell, secretary-treasurer, Cocoa.

Broward

Dr. Ernest E. Serrano of Hollywood was installed as president of the Broward County Medical Association at the regular meeting on December 28. Dr. Thomas F. Huey Jr. was chosen president-elect; Dr. Walter J. Glenn Jr., vice president; Dr. Alfred E. Cronkite, secretary; and Dr. Richard L. Foster, treasurer. All are from Fort Lauderdale.

WANTED — FOR SALE

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

INTERNIST: Age 31, family, military service completed, Diplomate, American Board of Internal Medicine, desires association with individual, group, or institution on a guaranteed income or salary basis, initially. Write 69-143, P.O. Box 1018, Jacksonville, Fla

GENERAL PRACTICE: Associate. Well established general practitioner with rapidly expanding practice in major West-Coast Florida industrial city desires young associate. Must have Florida boards. Once-in-a-lifetime opportunity for right man. Personal details and photo must accompany reply. Write 69-144, P.O. Box 1018, Jacksonville, Fla.

OBSTETRICIAN-GYNECOLOGIST: Florida native and licensure. Board eligible, excellent training. Married, age 32, category IV. Complete residency June 1955. Desire position or association with Obstetrician-Gynecologist or group in Miami or South Florida area but will consider good opportunity elsewhere. Write 69-145, P.O. Box 1018, Jacksonville, Fla.

Columbia

Re-elected to office in the Columbia County Medical Society were Drs. Robert B. Harkness, president; Laurie J. Arnold Jr., vice president; and Thomas H. Bates, secretary-treasurer, all of Lake City.

Dade

Dr. L. Washington Dowlen of Miami will serve as president of the Dade County Medical Association in 1955. Other officers elected at the regular December meeting include: Drs. Hunter B. Rogers, president-elect; Alfred G. Levin, vice president; Robert F. Dickey, secretary; and James J. Hutson, treasurer, all of Miami.

At the regular meeting on January 4, Drs. Howard A. Engle of Miami Beach and Robert P. Keiser of Coral Gables presented the scientific program. Dr. Engle spoke on "The Brain-Damaged Child" and Dr. Keiser, on "Present Care of Poliomyelitis."

DeSoto-Hardee-Highlands-Glades

The new officers of the DeSoto-Hardee-Highlands-Glades County Medical Society are Dr. Gordon H. McSwain, president; Dr. Charles H. Kirkpatrick, vice president; and Dr. Harold S. Agnew, secretary-treasurer. All of these officers are from Arcadia.

Duval

At the regular meeting of the Duval County Medical Society in December, Dr. Raymond H. King of Jacksonville was installed as president. Officers elected at the meeting include Drs. Joseph J. Lowenthal, president-elect; Lauren M. Sompayrac, vice president; and Eugene M. Frame, secretary. Re-elected treasurer was Dr. Sidney Stillman. All of these officers are from Jacksonville.

At the Society's meeting on January 4, a program on "Some Problems in the Practice of Avia-

tion Medicine," was given by Warren E. Klein, Captain (MC) U.S.N., E. R. Irons, Commander (MC) U.S.N., M. V. Skeen, Lieutenant (MC) U.S.N., E. S. Welch, Lieutenant (MC) U.S.N., and H. H. Howren, Lieutenant, j.g. (MC) U.S.-N.R.

Escambia

New president of the Escambia County Medical Society is Dr. George W. Morse. Other officers elected for 1955 are Drs. Gretchen V. Squires, president-elect, and Noel E. Mellen, vice president. Re-elected secretary-treasurer was Dr. Paul F. Baranco. All of these officers are from Pensacola.

Franklin-Gulf

At the annual meeting of the Franklin-Gulf County Medical Society on November 24, Dr. Warren T. Weathington of Apalachicola was elected president of the Society for 1955. Also elected were Drs. William F. Wager of Port St. Joe, vice president, and Joseph P. Hendrix, also of Port St. Joe, secretary-treasurer.

Hillsborough

At the meeting of the Hillsborough County Medical Society in December, Dr. Frank S. Adamo of Tampa was installed as president for the coming year. Dr. James N. Patterson was chosen president-elect, and Dr. Curtis G. Rorebeck was elected treasurer. Re-elected to office were Drs. Wesley W. Wilson, vice president, and Julien C. Pate Jr., secretary. All of these officers are from Tampa.

Indian River

New president of the Indian River County Medical Society is Dr. Kip G. Kelso. Re-elected to office were Drs. Erasmus B. Hardee, vice president, and Vernon L. Fromang, secretary-treasurer. All of these officers are from Vero Beach.

Jackson-Calhoun

President of the Jackson-Calhoun County Medcial Society for 1955 is Dr. Henry I. Langston of Marianna. Dr. Francis M. Watson of Marianna is secretary-treasurer.

You are invited to attend the joint meeting of

THE ATLANTA GRADUATE MEDICAL ASSEMBLY

and

THE SOUTHEASTERN SURGICAL CONGRESS

February 21-24, 1955
Atlanta Biltmore Hotel
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Among the speakers to appear on this program are: Dr. Waltman Walters, Mayo Clinic; Dr. George Crile, Jr., Cleveland; Dr. Chevalier L. Jackson, Philadelphia; Dr. Alton Ochsner; Dr. Elmer C. Bartels, Lahey Clinic; Dr. William Dameshek, Boston; Dr. Arthur M. Master, New York; Dr. George T. Pack, New York; Dr. Reid Nesbit, Ann Arbor.

The following symposia will be presented:

"Cancer of the Lung." Moderator: Dr. C. C. Aven. Collaborators: Drs. Burgess Gordon, George Pack, J. A. del Regata.

"Arthritis and Allied Diseases." Moderator: Dr. Vernon E. Powell. Collaborators: Drs. Currier McEwen, Elmer C. Bartels, Edgar S. Gordon.

"Angina Pectoris." Moderator: Dr. Eugene B. Ferris. Collaborators: Drs. Arthur Master, Herrman Blumgart, Robert Wilkins.

"Obstetrics and Gynecology." Moderator: Dr. John B. Cross. Collaborators: Drs. Roger Scott, Willis Brown, Meyer Saklad.

Note: Registration fee of $10.00 will admit you to all scientific sessions of both Assemblies. We URGE prompt registration and hotel reservation. Write Dr. B. T. Beasley, Secretary, Southeastern Surgical Congress, Hurt Building, Atlanta, or Mrs. S. R. Roberts, Executive Secretary, Atlanta Graduate Medical Assembly, 15 Peachtree Place, N. W., Atlanta.

Lake

The list of officers who will serve the Lake County Medical Society during 1955 appeared in the December 1954 Journal.

At the regular meeting of the Society on January 5, Dr. Fred Vincenti of Mount Dora spoke on "Ano-Rectal Diseases."

Lee-Charlotte-Collier-Hendry

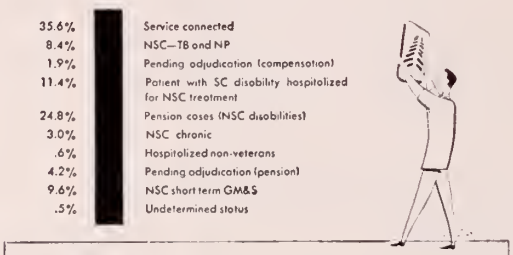
Newly-elected officers of the Lee-Charlotte-Collier-Hendry County Medical Society are Drs. Baker Whisnant, president, and Joseph L. Selden Jr., vice president. Re-elected secretary-treasurer was Dr. James L. Bradley Jr. All of these officers are from Fort Myers.

Dr. Albert A. Wilson of Tampa was guest speaker at the November 23 meeting of the Society.

Leon-Gadsden-Liberty-Wakulla-Jefferson

Officers of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society for 1955 are Drs. William L. Hunger, president, Monticello; and Robert H. Mickler, vice president, Tallahassee. Dr. Odis G. Kendrick Jr. of Tallahassee was re-elected secretary-treasurer.

In Viewing the VA Medical Program . . .



VA explanation of patient load on a given day

The above classification is presented by the VA as an explanation of the large non-service-connected patient load in its hospitals. The medical profession recommends that only the first category and those in the third whose disabilities are determined to be service-connected should be entitled to federal medical care. Non-service-connected TB and NP cases should continue to be treated on a temporary basis until community and state facilities can be readied. The remaining groups obviously have no service-connection and are hospitalized for illnesses or injuries incurred in civilian life.

Manatee

Dr. Marjorie L. Warner of Bradenton is the new president of the Manatee County Medical Society, and Dr. Harvey C. Pauley Jr., also of Bradenton, is secretary.

Marion

At the regular monthly meeting of the Marion County Medical Society on December 21, the following officers were elected for 1955: Drs. William H. Turnley, president, and Harry S. Gibboney Jr., vice president, both of Ocala. Re-elected secretary-treasurer was Dr. Bertrand F. Drake, also of Ocala.

Monroe

New officers of the Monroe County Medical Society are Drs. Ralph Herz, president, and William R. Ploss, secretary-treasurer, both of Key West.

Nassau

At a meeting of the Nassau County Medical Society on December 10, Dr. David G. Humphreys was re-elected president of the Society for 1955. Also re-elected were Dr. Benjamin F. Dickens, vice president, and Dr. John W. McClane, secretary-treasurer. All three officers are from Fernandina Beach.

Orange

New president of the Orange County Medical Society is Dr. Don C. Robertson of Orlando. Other officers elected for 1955 are Drs. Thomas C. Butt, president-elect; Edgar E. Hitchcock, vice president; Walter A. Derrick, secretary, and Thomas R. Collins, treasurer, all of Orlando.

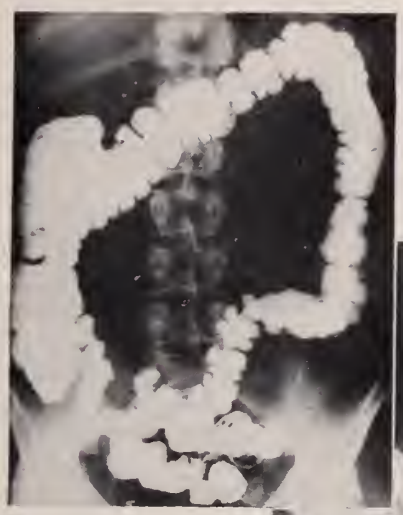
Dr. Frederick H. Bowen of Jacksonville, chairman of the Association's sub-committee to the Board of Governors on Veterans Care, will be the guest speaker at the February 16 meeting of the Society.

Palm Beach

Dr. Edwin W. Brown of West Palm Beach is the newly-installed president of the Palm Beach County Medical Society. Dr. Walter R. Newbern was elected president-elect; Dr. Edward W. Wood, vice president; and Dr. James R. Anderson, secretary. Dr. Russell D. D. Hoover was re-elected treasurer. All are from West Palm Beach.

(Continued on page 668)

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Metamucil is supplied in containers of 4, 8 and 16 ounces. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

SEARLE

(Continued from page 666)

Pasco-Hernando-Citrus

New president of the Pasco-Hernando-Citrus County Medical Society for 1955 is Dr. Harry G. Brownlee of Zephyrhills. Officers re-elected were Drs. Gail M. Osterhout, vice president, Inverness; S. Carnes Harvard, vice president, Brooksville, and W. Wardlaw Jones, secretary-treasurer, Dade City.

Pinellas

The list of officers who will serve the Pinellas County Medical Society during 1955 appeared in the December 1954 Journal.

At the February 7 meeting of the Society, Dr. George T. Harrell Jr., Dean of the University of Florida Medical School, was guest speaker.

Polk

President of the Polk County Medical Association for 1955 is Dr. Samuel J. Clark of Lakeland. Other officers elected are Drs. James T. Shelden, president-elect, Lakeland; William W. Hardman, vice president, Winter Haven; and Marion W. Hester, secretary-treasurer, Lakeland.

At the regular meeting of the Association on January 12, guests were Dr. Edward Jelks, Harold Parham, Supervisor of the Association's Bureau of Public Relations, and Tom Jarvis, Assistant Supervisor, all of Jacksonville.

Putnam

Dr. Grover C. Collins of Palatka was elected president of the Putnam County Medical Society for the coming year. The new secretary-treasurer is Dr. Alfred P. Peretti, also of Palatka.

St. Johns

New officers of the St. Johns County Medical Society for 1955 are Drs. George C. Hopkins, president; Richard J. Langston, vice president; and Milton Segal, treasurer, all of St. Augustine. Re-elected secretary was Dr. Reuben J. Plant Jr. also of St. Augustine.

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St. Lucie-Okeechobee-Martin

New president of the St. Lucie-Okeechobee-Martin County Medical Society for 1955 is Dr. Henry E. Branca of Fort Pierce. Dr. Julian D. Parker of Stuart was elected vice president, and Dr. Adrian M. Sample of Fort Pierce was re-elected secretary-treasurer.

Sarasota

New officers of the Sarasota County Medical Society are Drs. Melvin M. Simmons, president, and Andrew J. Jesacher, secretary, both of Sarasota. Re-elected treasurer was Dr. Millard B. White, also of Sarasota.

Seminole

The officers of the Seminole County Medical Society for 1955 are Drs. John M. Morgan, president; William V. Roberts, vice president; and Terry Bird, who was re-elected secretary-treasurer. All are from Sanford.

Suwannee

Dr. William P. Blackmon of Mayo was re-elected president, and Dr. Hiram B. Curry of Jasper was re-elected secretary-treasurer of the Suwannee County Medical Society for 1955. The new vice president of the Society is Dr. John N. Sims of Live Oak.

Volusia

At the regular meeting of the Volusia County Medical Society on December 14, the following officers were elected: Dr. Robert L. Miller, Daytona Beach, president; Dr. Theodore F. Hahn Jr., DeLand, vice president; and Dr. Achille A. Monaco, Daytona Beach, secretary-treasurer.

Dr. Miller had served as secretary-treasurer of the Society for the past 24 years.

Guest speaker at this meeting was Dr. Clifford C. Snyder of Miami who spoke on "Reconstructive Surgery."

Walton-Okaloosa

Officers of the Walton-Okaloosa County Medical Society for 1955 are Dr. Richard H. Lee, Crestview, president; Dr. A. Grady Williams Jr., Valparaiso, vice president; and Dr. Frederic E. Caldwell, Fort Walton Beach, secretary-treasurer.

Washington-Holmes

President of the Washington-Holmes County Medical Society for 1955 is Dr. L. H. Paul of Bonifay. Dr. Bayllye W. Dalton of Chipley was re-elected secretary-treasurer.



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MRS. DAVID R. MURPHEY JR. Research and Romance of Medicine .....*Tampa*
MRS. A. FRED TURNER JR., Nominating.....*Orlando*

Auxiliary Alive and Working in 1955

We have a brand new baby! It is a healthy, lusty and growing baby. It was born on Oct. 16, 1954, at an organization meeting held at the home of Mrs. William D. Sugg, Bradenton, and has been named the Woman's Auxiliary to the Manatee County Medical Society. It started out with 20 members, and we will see it grow and grow during this year. This is our twenty-second baby, our oldest being over 28 years old.

We also have some starts on brand new babies, having members-at-large to the Florida Medical Auxiliary in several of our counties including Indian River, Highlands, DeSoto, Pasco, Washington, Gulf, Franklin and many others. We are looking for other brand new babies from these members-at-large and know that in the near future we can look to many of them to organize also.

Every once in a while, not too frequently any longer, but now and then, some doctor from a county society where there is no organized auxiliary will say to me—"Why do you think we should have an auxiliary? Our women are all friends and all are out working in our community and are a part of it, so why should we be bothered to ask our wives to organize an auxiliary?" The best answer to this is to say to them, "Why do you have a medical society? Your doctors all read their journals, take postgraduate courses, work in their communities and are good friends, so why have a medical society?" Their answers are always about the same and include a phrase about "We are different." I am still figuring out what makes them different, or trying to.

I wish that every doctor in a medical society in Florida with no organized auxiliary could talk with the men from the counties where auxiliaries have been organized and find out what the auxiliary has meant to them. Let me give you some examples.

If you have an exhibit at a county fair or exposition, your auxiliary will help you staff it. If you have a desire to really know each other better as persons and not just as doctors, your auxiliary will have a Doctor's Day which shows the solidarity of the doctor's family, gives the public a knowledge of the appreciation of the doctor's wife has for him as a fine man as well as a doctor, gives an opportunity to doctors to know each other as people as well as doctors. If you have conventions in your part of the state, your wives will decorate, plan entertainment, take registration, staff exhibits, et cetera. If you have new doctors coming into your part of the state, the doctor's wife is made to feel at home through her auxiliary and to know other doctors' wives and to help the new doctor get acquainted and become a part of your community.

Further, through auxiliary there are specific projects which are carried on in the interest of medicine which are not carried on through the

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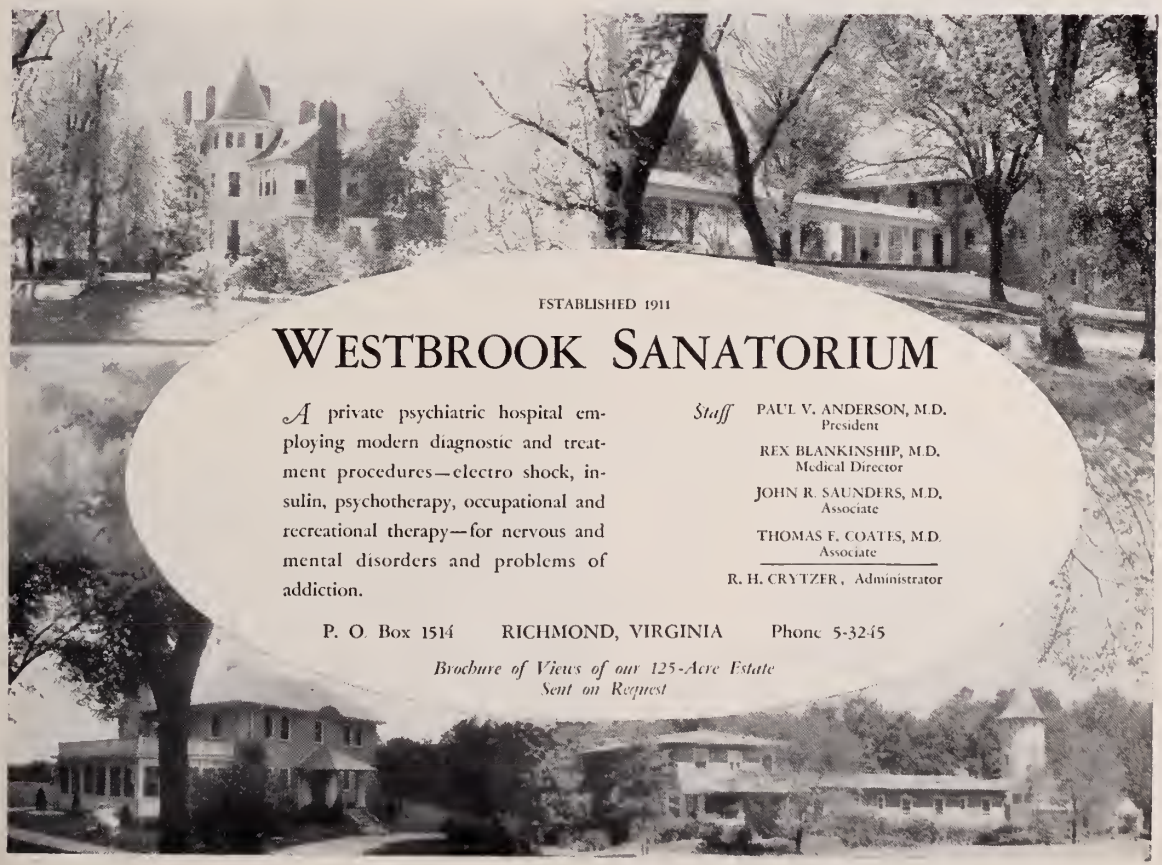
other organizations in town. These include interpretation of the doctor to his community, helping as his help-mate on committees in his community, aiding in nurse recruitment, helping swell the funds of AMEF which is keeping our medical schools free from government control, interpreting to the community the doctors' attitude on legislation at community, state and federal level, aiding in the distribution of health information through promotion of *Today's Health* and other AMA media of public relations and health information. Perhaps, most important, always learning how to be a better doctor's wife for none of us is perfect and all of us can continue to learn how to do a better job in this way.

The list could go on and on, but the reasons are too numerous to name all at once. Ask the doctor in the county where they have an auxiliary — he will give you more reasons than we can write as to why he thinks an auxiliary is important to the medical profession.

The Florida Medical Auxiliary through its president and organization committee with Mrs. Albert G. Love IV, Gainesville, as chairman and representative from District B; Mrs. William D. Rogers, Chattahoochee, District A; Mrs. John P. Ferrell, St. Petersburg, District C; and Mrs. Charles McD. Harris Jr., West Palm Beach, District D, will gladly give you information and help in any way they can.

It is well for county societies to remember that no auxiliary is organized without the consent of the medical society, and without this consent, our hands are tied. There were about 2,600 members of the Medical Association in 1954, and 1,455 members of the Medical Auxiliary. We are anxious to see the wives stand side by side with their husbands in their beliefs and policies concerning medicine in their communities. Without your willingness and help, however, we cannot move. HELP US BE ALIVE AND WORKING 100 PER CENT IN 1955 by writing to Mrs. Richard F. Stover, 1631 N. W. 10th St., Miami 35, or to Mrs. Albert G. Love IV, 710 N. W. 6th St., Gainesville, and requesting that an auxiliary be formed in your county. No matter how few of you there are, WE NEED YOUR HELP.

Mrs. Richard F. Stover, President



OBITUARIES

Harry Alexander Peyton

Dr. Harry Alexander Peyton of Jacksonville died at Riverside Hospital in that city on Oct. 17, 1954, following a heart attack. He was 70 years of age.

A native of Bolton, Miss., where he was born on March 3, 1884, Dr. Peyton received his academic training at Lehigh University and was awarded the degree of Doctor of Medicine by the George Washington University School of Medicine in 1910. After completing an internship at Garfield Memorial Hospital in Washington, D. C., in 1911, he served the United States government at Ancon Hospital in Panama for a year. In 1913 he received special training in urology under Dr. Hugh Young in Baltimore.

Dr. Peyton entered the private practice of medicine in Jacksonville in 1914 as a general surgeon. During World War I he was a major in the Army Medical Corps, serving overseas. Upon completion of military service, he returned to Jacksonville and in 1919 joined Dr. Edward Jelks and Dr. Turner Z. Cason in group practice. In 1920 they purchased Riverside Hospital, where he continued to practice general surgery until his retirement in 1949. Thereafter, he devoted much time to the Blood Bank of Jacksonville. Locally, he held membership in the Civitan Club, the Timuquana Country Club and the Church of the Good Shepherd.

Dr. Peyton was a member of the Duval County Medical Society. For 40 years he had been a member of the Florida Medical Association, holding life membership the last six years. He also was affiliated with the American Medical Association, Southern Medical Association, Southeastern Surgical Congress and American College of Surgeons. He was certified by the American Board of Surgery. His fraternities were Phi Chi and Phi Gamma Delta.

Surviving are the widow, Mrs. Nellie Allen Peyton; two sons, Harry Peyton, of Houston, Texas, and John Peyton, of Jacksonville; one daughter, Mrs. Virginia Peyton McDonough, of Dallas, Texas; one brother, T. L. Peyton, of Washington, D. C.; two sisters, Mrs. Marshall Magruder of Atlanta, Ga., and Mrs. John Sullivan, of Washington, D. C., and five grandchildren.



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BOOKS RECEIVED

Current Concepts in Digitalis Therapy. By Bernard Lown, M.D., and Samuel A. Levine, M.D. Pp. 164. Price $3.50. Boston, Little, Brown and Company, 1954.

The physician who treats the cardiac patient will find this book invaluable. Sooner or later he has to employ one of the group of digitalis drugs to improve the function of a failing myocardium, and here is presented a thorough yet concise guide for the use of these drugs. It answers succinctly such questions as: When is digitalis to be administered? Which of the many preparations is to be employed? How is digitalization to be achieved and maintained? How is toxicity to be recognized and treated?

For the first time both experimental and clinical evidence are provided, demonstrating the profound relationship between the state of the body electrolytes and the action of digitalis. The present practice of sodium restriction in the management of heart failure makes this relationship a subject of more vital concern to every clinician than ever before. The book, furthermore, provides a method for determining digitalis requirements when these are in doubt. Specific case histories are presented, illustrating methods of recognizing and correcting overdigitalization and underdigitalization. The authors unify theory, laboratory experiment and clinical practice to give common sense direction to the physician faced with the care of a patient in heart failure.

Much of this material first appeared in the New England Journal of Medicine. Interest was so great that it was published in this book, with additional material of practical value. Among the new subjects are methods of digitalization, suggestions about which of the many digitalis drugs are to be utilized, a discussion of the arrhythmias resulting from digitalis overdosage, the indications for and hazards of potassium and Pronestyl therapy, and many practical suggestions concerning management of patients in congestive heart failure. The bibliography is complete and assembles for the first time a reference list of immense value to all workers in the field.

Dr. Lown worked on digitalis in New York and then at Harvard University and presented part of his work at the Second International Congress of Cardiology. Dr. Levine is clinical Professor of Medicine at Harvard Medical School and Physician at Peter Bent Brigham Hospital. He is well known for his books on heart disease.

Hugh Roy Cullen, A Story of American Opportunity. By Ed Kilman and Theon Wright. Pages 376. Price $4.00. New York, Prentice-Hall, Inc., 1954.

This biography of millionaire Texas oilman-philanthropist Hugh Roy Cullen of Houston is the success story of a living example of some of the great axioms of this nation. It substantiates the fact that opportunity in America is still alive, that the individual is important, and that faith is a vital ingredient in successful living. This "king of the Texas wildcatters" rose from extremely modest circumstances to become one of this country's wealthiest men and one of the greatest philanthropists of all time. To the Cullen Foundation, which distributes funds for philanthropic purposes, he has given oil properties worth $160,000,000. Not long ago, he set up four million-dollar funds in two days, an all time record in altruism in which four hospitals, of four different denomiations, benefited to an exactly equal degree. Houston's Texas Medical Center has benefited by $7,367,000 in Cullen endowments and gifts.

Said this typical small town boy, who through unwavering faith in the future of America and unceasing toil rose to uncountable wealth and world renown (Time, Dec. 13, 1954): "I became convinced that the only way to counteract some of the false theories abroad in the land would be to meet these with the true story of an American boy who by hard work, faith, honesty and courage, pushed obstacles aside and succeeded in life only because he lived in a land which permitted individual initiative to prosper. If this biography should in some small measure impart to the youth of America that they also can succeed . . ."

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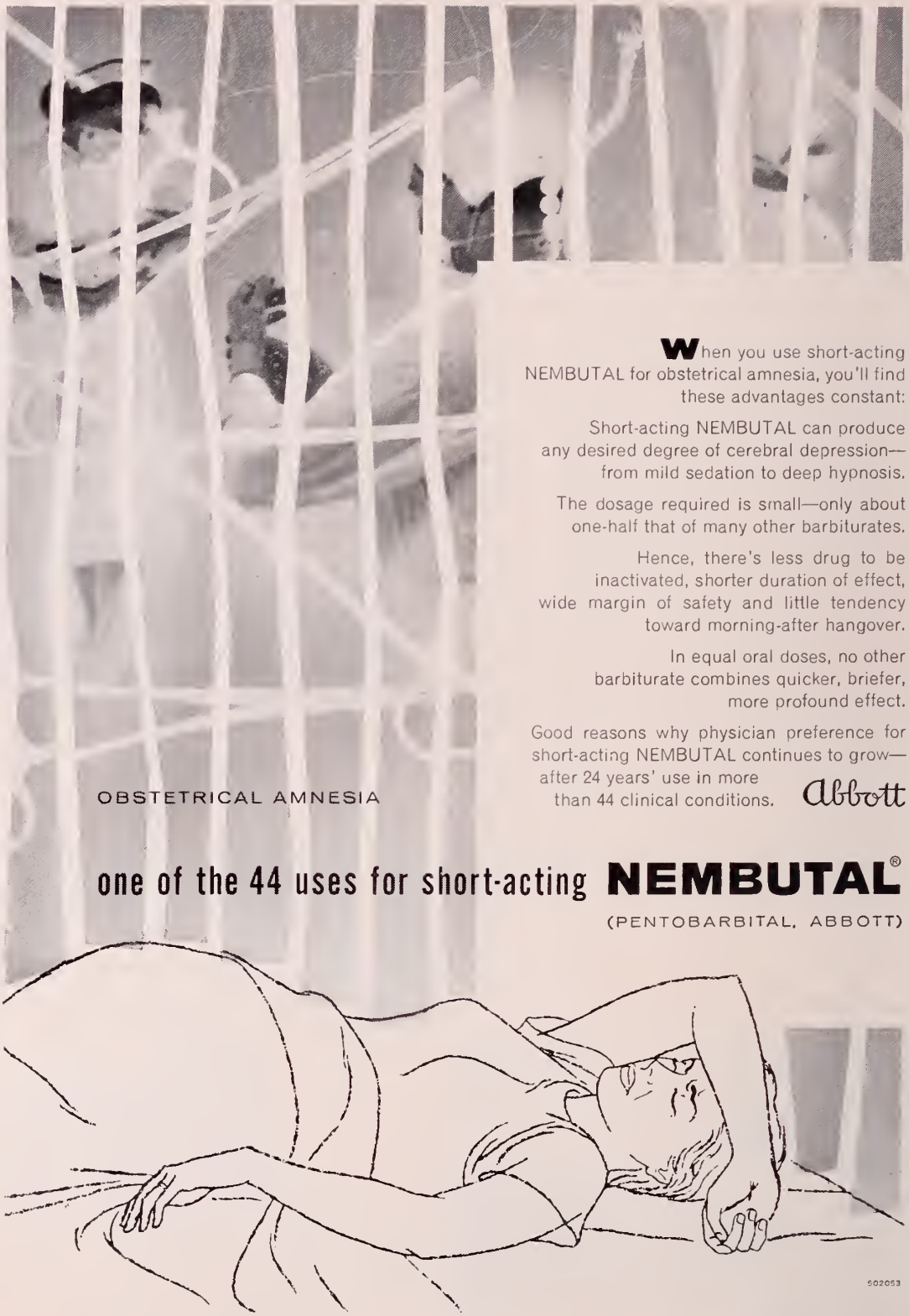
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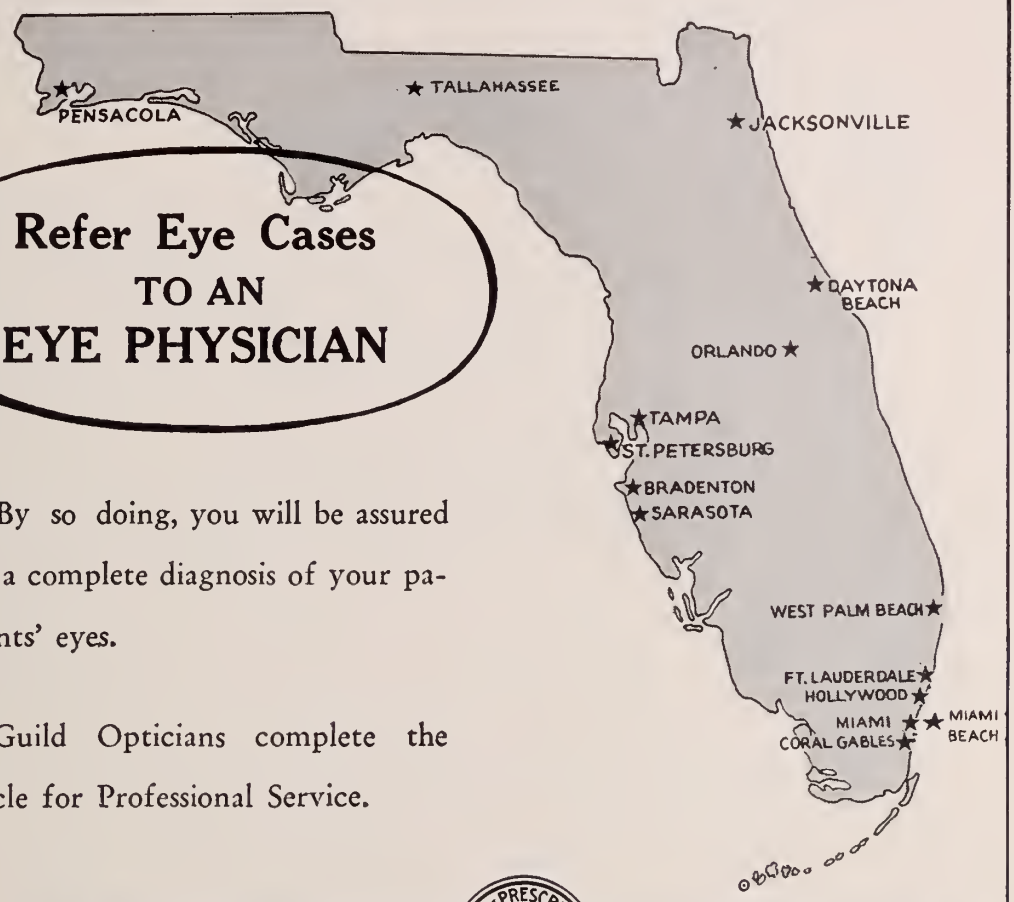
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	T. S. Budd	122 S. E. First St.
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	Ralph White	Tampa Theater Bldg.
Orlando	Burt J. Rutledge	392 N. Orange Ave.
	E. A. Howard	Metcalf Bldg.
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Daytona Beach	Harvey E. White	220 S. Beach St.
Pensacola	Bennie Barberi	18 W. Garden St.
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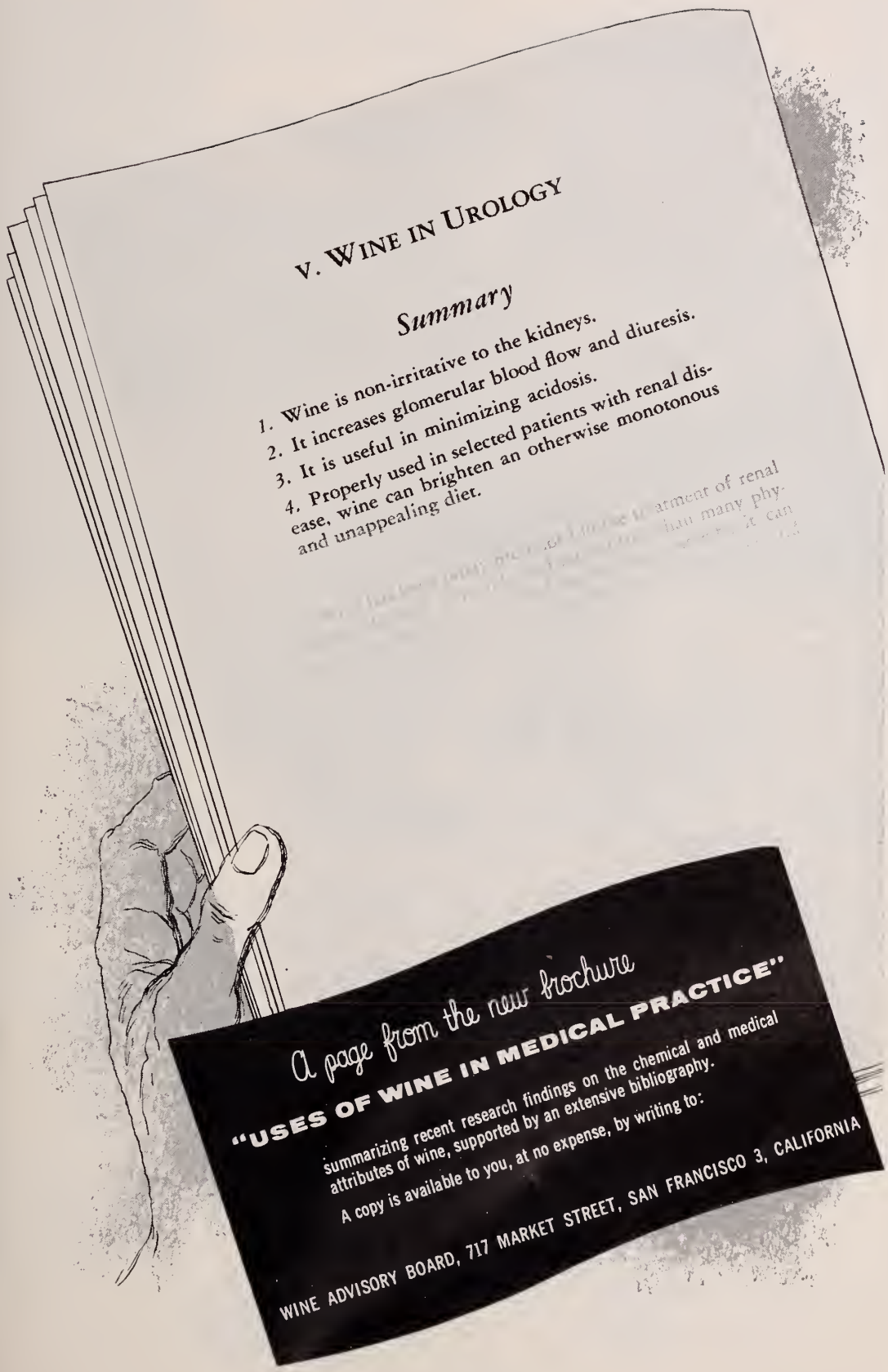
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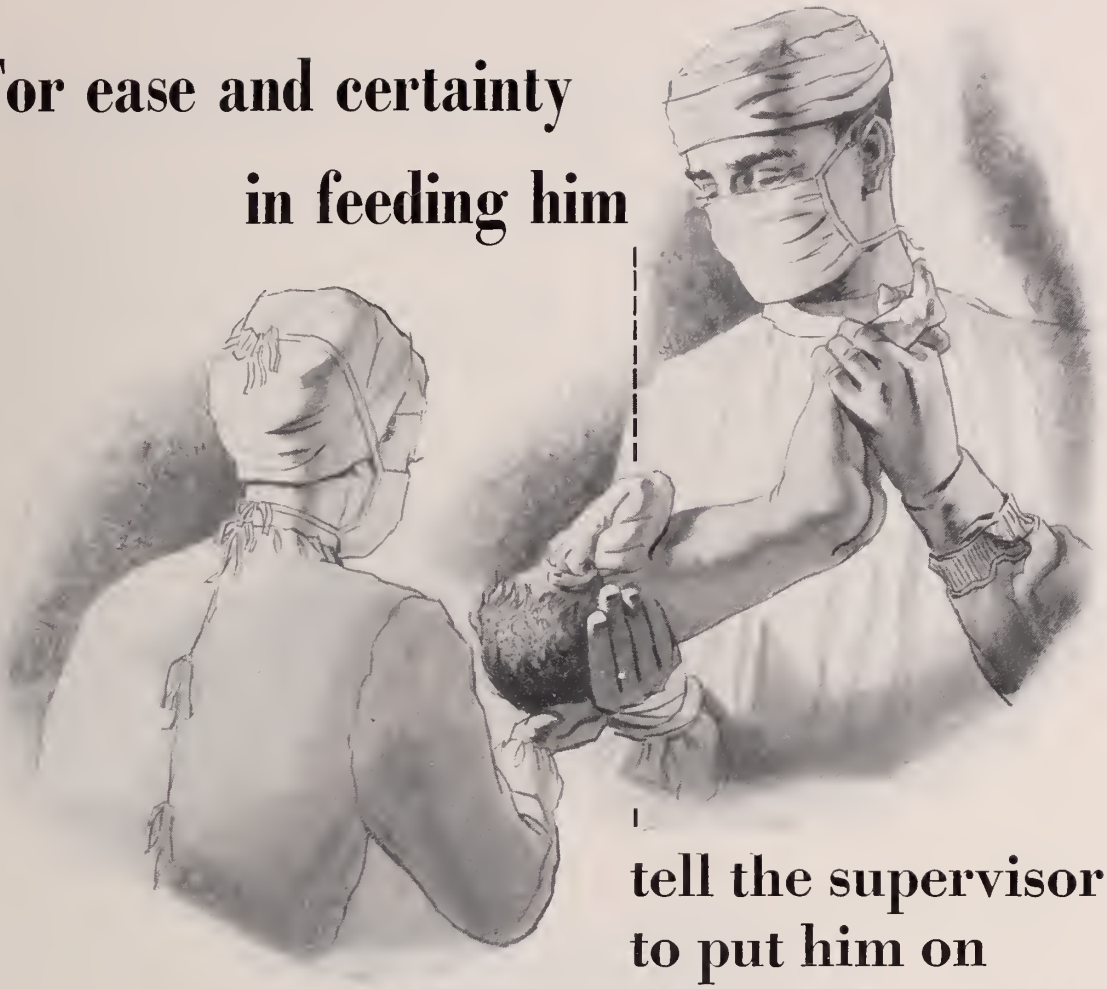
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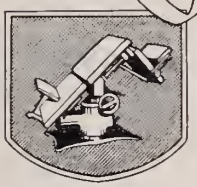
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
la Medical Association	Duncan T. McEwan, Orlando	Samuel M. Day, Jacksonville	St. Petersburg, Apr. 3-6, '55
la Medical Districts	Francis H. Langley, St. Petersburg	Council Chairman	
Northwest	William H. Hixon, Pensacola	George S. Palmer, Tallahassee	Pensacola
Northeast	Henry J. Babers Jr., Gainesville	Thomas C. Kenaston, Cocoa	Gainesville
Southwest	Clyde O. Anderson, St. Petersburg	James R. Boulware Jr., Lakeland	Lakeland
Southeast	James R. Sory, West Palm Beach	Russell B. Carson, Ft. Lauderdale	Fort Lauderdale
la Specialty Societies	Leonard L. Weil, Miami Beach	Leon S. Eisenman, Hialeah	St. Petersburg, Apr. 3, '55
my of General Practice	Solomon D. Klotz, Orlando	Edwin P. Preston, Miami	" "
y Society	R. Gaylord Lewis, West Palm Beach	Harry E. Bierley, West Palm Beach	" "
hesiologists, Soc. of	DeWitt C. Daughtry, Miami	Jack Reiss, Coral Gables	" "
Phys., Am. Coll., Fla. Chap.	Hollis F. Garrard, Miami	Joseph A. J. Farrington, Jacksonville	" "
. and Syph., Assn. of	Thomas E. Morgan, Jacksonville	Lorenzo L. Parks, Jacksonville	" Apr. 4, '55
h Officers' Society	Plumer J. Manson, Miami	John H. Mitchell, Jacksonville	" Apr. 5, '55
trial and Railway Surgeons	Sullivan G. Bedell, Jacksonville	Roger E. Phillips, Orlando	" Apr. 3, '55
ology & Psychiatry	Harold G. Nix,Tampa	Reuben B. Chrisman Jr., Miami	" Apr. 5, '55
nd Gynec. Society	G. Tayloe Gwathmey, Orlando	Carl S. McLemore, Orlando	" Apr. 3, '55
hal. & Otol., Soc. of	John F. Lovejoy, Jacksonville	Newton C. McCollough, Orlando	" "
pedic Society	Millard B. White, Sarasota	James B. Leonard, Clearwater	" "
ologists, Society of	Lewis T. Corum, Tampa	Joel V. McCall Jr., Daytona Beach	" Apr. 5, '55
tric Society	Claude G. Mentzer, Miami	George Williams Jr., Miami	" Apr. 2, '55
ologic Society	A. Judson Graves, Jacksonville	James T. Shelden, Lakeland	" Apr. 2-3, '55
ological Society	Frederick J. Waas, Jacksonville	C. Frank Chunn, Tampa	" Apr. 3, '55
ons, Am. Coll., Fla. Chapter	Linus W. Hewit, Tampa	Frank J. Pyle, Orlando	" "
gical Society			
da—	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, May 14, '55
sic Science Exam. Board	John T. Stage, Jacksonville	John B. Ross, Jacksonville	St. Petersburg, 1955
od Banks, Association	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	
ue Cross of Florida, Inc.	David R. Murphey Jr., Tampa	Jack O. W. Rash, Miami	
ue Shield of Florida, Inc.	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	St. Petersburg, Apr. 3, '55
ncer Council	Sidney Davidson, Lake Worth	Edward R. Smith, Jacksonville	
nical Diabetes Assn.	Robt. Thoburn, D.D.S.,Daytona Bch	J. E. Edwards, D.D.S., Coral Gables	Jacksonville, Apr. 23-25, '55
ntal Society, State	Alvin E. Murphy, Palm Beach	Daniel R. Usdin, Jacksonville	April 1955
art Association	Mr. J. F. Wymer Jr., W. Palm B.	Mrs. Mary Reeder, Miami	
spital Association	Frank D. Gray, Orlando	Homer L. Pearson Jr., Miami	Jacksonville, June 20-25, '55
edical Examining Board	Turner Z. Cason, Jacksonville	Chairman	
edical Postgraduate Course	Miss Dorothy Jackson, C. Gables	Mrs. Lulla F. Bryan, Miami	
urse Anesthetists, Fla. Assn.	Martha Wolfe, R.N., Coral Gables	Agnes Anderson, R.N., Orlando	
urses Association, State	Mr. J. L. McDonald, St. Augustine	Mr. R. Q. Richards, Ft. Myers	Clearwater, May 23-25, '55
armaceutical Association, State	Mr. J. A. Mulrennan, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Daytona Beach, '55
blic Health Association	Lawrence C. Manni, Tallahassee	Simon D. Doff, Jacksonville	Miami, May 12-14, '55
udeau Society	Judge Ernest E. Mason, Pensacola	Mrs. W. J. Norton, Sarasota	Miami, May 12-14, '55
berculosis & Health Assn.	Mrs. Richard F. Stover, Miami	Mrs. S. J. Wilson, Ft. Lauderdale	St. Petersburg, Apr. 3, '55
oman's Auxiliary	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	Atlantic City, June 6-10, '55
rican Medical Association	Edward J. McCormick. Toledo. O.	Geo. F. Lull. Chicago	Boston, Nov. 29-Dec. 2, '55
M.A. Clinical Session	Robt. L. Sanders, Memphis, Tenn.	Mr. V. O. Foster, Birmingham	Houston, Nov. 14-17, '55
hern Medical Association	J. M. Donald, Birmingham	Douglas L. Cannon, Montgomery	Montgomery, Apr. 21-23, '55
ama Medical Association	Peter B. Wright, Augusta	David Henry Poer, Atlanta	Augusta, May 1-4, '55
rgia, Medical Assn. of	Mr. John W. Gill, Vicksburg, Miss.	Mr. Pat Groner, Pensacola	Atlanta, Apr. 20-22, '55
Hospital Conference	W. L. Rucks, Memphis, Tenn.	Kath. B. MacInnis, Columbia, S. C.	Orlando, Mar. 25-26, '55
heastern Allergy Assn.	Sam L. Raines, Memphis, Tenn.	Robert F. Sharp, New Orleans	New Orleans Mar. 20-23, '55
heastern, Am. Urological Assn.	J. Duffy Hancock, Louisville, Ky.	B. T. Beasley, Atlanta	Atlanta, Mar. 7-10, '55
heastern Surgical Congress	Walter C. Payne Sr., Pensacola	Barkley Beidleman, Pensacola	Pensacola, Oct. 27-28, 1955
Coast Clinical Society			

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County Medical Societies of Florida

SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Active Members
Alachua	Edwin H. Andrews, Gainesville	Henry S. Blank, Gainesville	2nd Tues.	51
Bay	William F. Humphreys, Panama City	Roderick C. Webb, Panama City	1st Tues.	26
Brevard	Lee Rogers Jr., Cocoa	Charles E. Russell, Cocoa	2nd Tues.	27
Broward	Ernest E. Serrano, Hollywood	Alfred E. Cronkite, Fort Lauderdale	4th Tues.	113
Columbia	Robert B. Harkness, Lake City	Thomas H. Bates, Lake City	1st Mon.	11
Dade	L. Washington Dowlen, Miami	Robert F. Dickey, Miami	1st Tues	672
De-Soto-Hardee-Highlands-Glades	Gordon H. McSwain, Arcadia	Harold S. Agnew, Arcadia	1st Tues.	27
Duval	Raymond H. King, Jacksonville	Eugene M. Frame, Jacksonville	1st Tues.	284
Escambia	George W. Morse, Pensacola	Paul F. Baranco, Pensacola	2nd Tues.	104
Franklin-Gulf	Warren T. Weathington, Apalachicola	Joseph P. Hendrix, Port St. Joe	Last Wed.	7
Hillsborough	Frank S. Adamo, Tampa	Julien C. Pate Jr., Tampa	1st Tues.	180
Indian River	Kip G. Kelso, Vero Beach	Vernon L. Fromang, Vero Beach	2nd Tues.	8
Jackson-Calhoun	Henry I. Langston, Marianna	Francis M. Watson, Marianna	Quarterly	16
Lake	Louis R. Bowen, Eustis	J. Basil Hall, Tavares	1st Wed.	27
Lee-Charlotte-Collier-Hendry	Baker Whisnant, Fort Myers	James L. Bradley, Fort Myers	3rd Mon.	37
Leon-Gadsden-Liberty-Wakulla-Jefferson	William L. Hunter, Monticello	Odis G. Kendrick Jr., Tallahassee	Quarterly	55
Madison	Wallace E. Winter, Madison	Julian M. DuRant, Madison		5
Manatee	Marjorie L. Warner, Bradenton	Harvey C. Pauley Jr., Bradenton	2nd Tues.	24
Marion	William H. Turnley, Ocala	Bertrand F. Drake, Dunnellon	3rd Tues.	28
Monroe	Ralph Herz, Key West	William R. Ploss, Key West	2nd Thurs.	11
Nassau	David G. Humphreys, Fernandina Beach	John W. McClane, Fernandina Beach	Last Fri.	10
Orange	Don C. Robertson, Orlando	Walter A. Derrick, Orlando	3rd Wed.	175
Palm Beach	Edwin W. Brown, West Palm Beach	James R. Anderson, West Palm Beach	4th Mon.	136
Pasco-Hernando-Citrus	Harry G. Brownlee, Zephyrhills	W. Wardlaw Jones, Dade City	2nd Thurs.	15
Pinellas	Clyde O. Anderson, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	208
Polk	Samuel J. Clark, Lakeland	Marion W. Hester, Lakeland	2nd Wed.	85
Putnam	Grover C. Collins, Palatka	Alfred P. Peretti, Palatka	2nd Tues.	10
St. Johns	George C. Hopkins, St. Augustine	Reuben J. Plant Jr., St. Augustine	3rd Tues.	19
St. Lucie-Okeechobee-Martin	Henry E. Branca, Fort Pierce	Adrian M. Sample, Fort Pierce	3rd Thurs.	22
Sarasota	Melvin M. Simmons, Sarasota	Andrew J. Jesacher, Sarasota	2nd Tues.	51
Seminole	John M. Morgan, Sanford	Terry Bird, Sanford	2nd Tues.	20
Suwannee	William P. Blackmon, Mayo	Hiram B. Curry, Jasper	1st Sat.	9
Taylor	George H. Warren, Perry	Walter J. Baker, Foley	Last Fri.	4
Volusia	Robert L. Miller, Daytona Beach	Achille A. Monaco, Daytona Beach	2nd Tues.	78
Walton-Okaloosa	Richard H. Lee, Crestview	Frederic E. Caldwell, Fort Walton Beach	3rd Tues	18
Washington-Holmes	L. H. Paul, Chipley	Bayllye W. Dalton, Chipley		4
			Total	2,577

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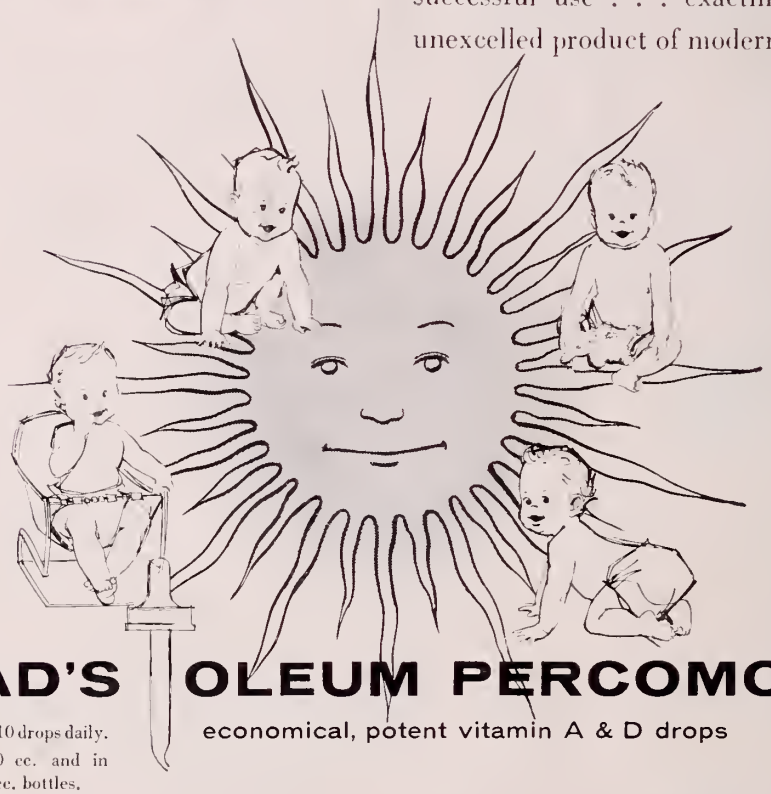
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Vol. XLI MARCH, 1955 No. 9

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IN THIS ISSUE

Muscular Dystrophy in South Florida
John E. Burch, William Pollen
and G. Thomas Samartino

Epilepsy
William H. McCullagh

Hemorrhage From Esophageal Varices
Abbott Y. Wilcox Jr.

Bone Marrow Examination
O. Whitmore Burtner

Malpractice Insurance Problem
Part IV

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Volume XLI MARCH, 1955 No. 9

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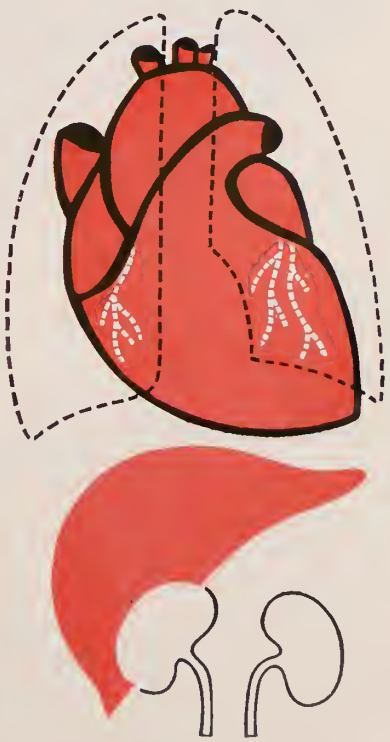
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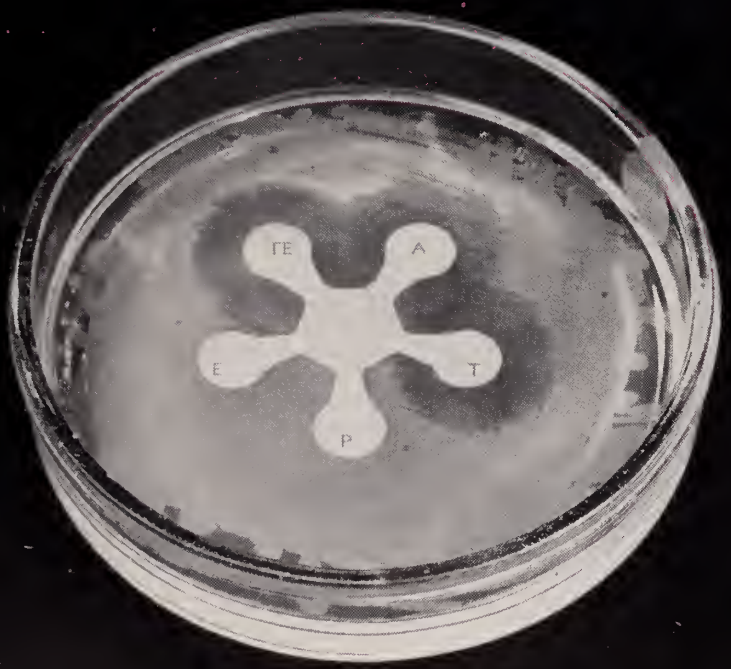
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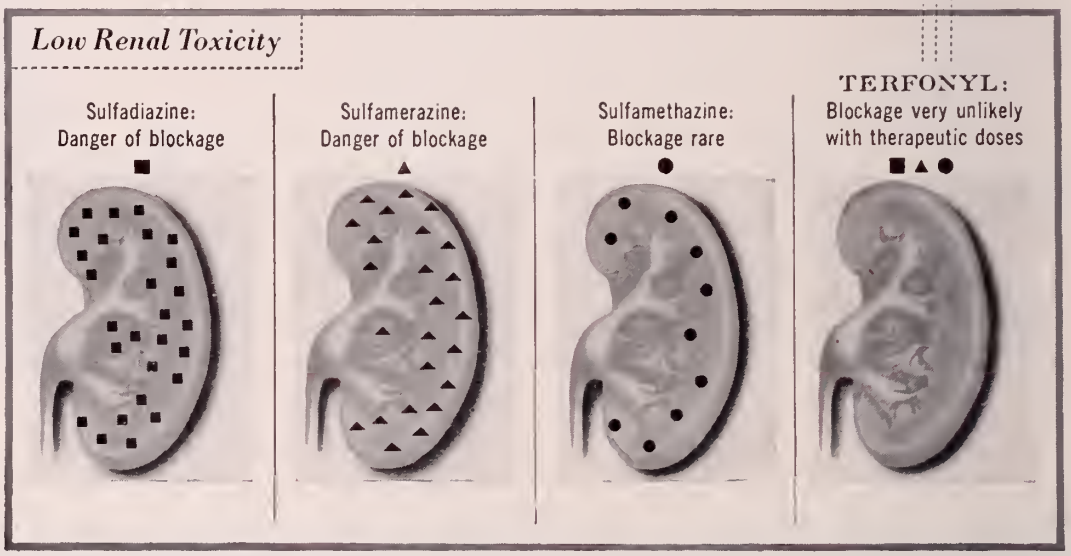
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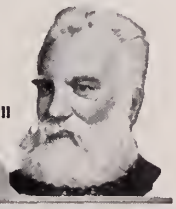

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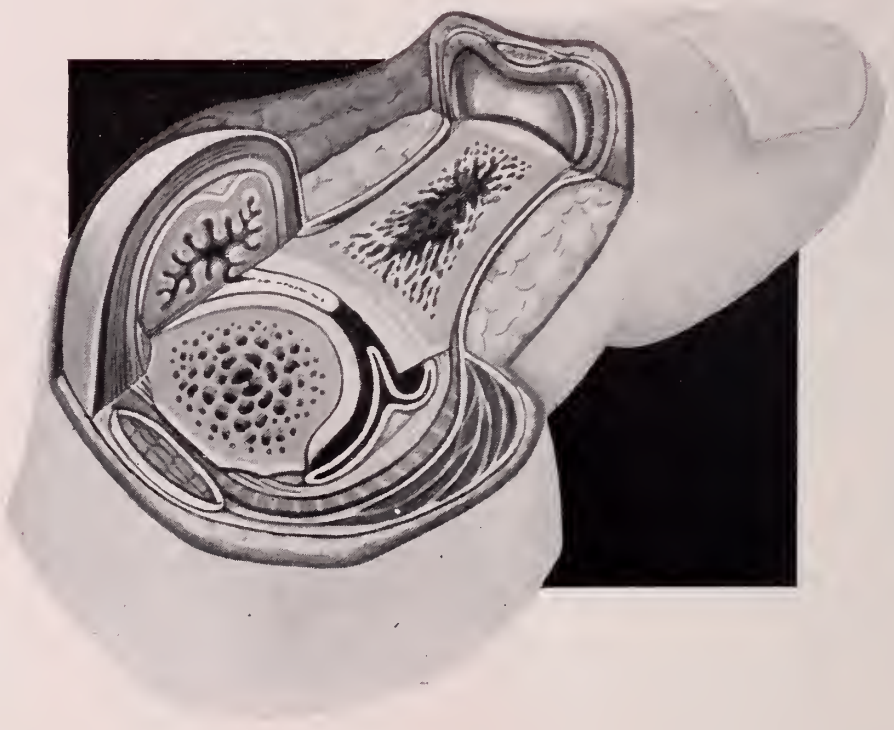
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*Bunim, J. J.: Research Activities in Rheumatic Diseases, Pub. Health Rep. *69*:437, 1954.



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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XLI | Jacksonville, Florida, March, 1955 | No. 9

Muscular Dystrophy in South Florida

JOHN E. BURCH, M.D.
WILLIAM POLLEN, M.D.
AND
G. THOMAS SAMARTINO, M.D.
MIAMI

This is a preliminary report of a clinical study of 20 patients with progressive muscular dystrophy, who have been observed for the past eight months in a clinic devoted to the study of this disease. Our series consists of 5 adults and 15 children. The children ranged in age from 3 to 18 years; 14 were males, 1 female. All but 1 of the adult patients, whose average age was 35 years, were ambulatory and able to carry on moderate outside activity. Of the 15 children, only 4 were still ambulatory, 11 being completely incapacitated and spending the major portion of their time in wheel chairs.

Our first objective was to study the early ambulatory cases of the childhood variety and decide if it was possible to prevent the serious contractures from developing, by means of physiotherapy and the use of corrective braces and night splints.

Our second objective was to evaluate the Van Meter treatment, which was described by Van Meter in October 1953. He reported rather remarkable results in 10 unselected cases of progressive muscular dystrophy.

In November 1953, we placed our patients on the Van Meter regimen, which consisted of the oral administration of a protein hydrolysate,* consisting of a mixture of amino acids, with the addition of a capsule** containing Vitamin B_{12} and folic acid. These patients were instructed in the method of administration of the medication and have been receiving this medication for a period of approximately six months. Up to the present time there has been no improvement in the dystrophic process. Occasionally, a parent would volunteer that there was some improvement in strength and less fatigue in a child and, also, less of a tendency to fall, but, other than these subjective remarks, we have found nothing on objective examination of each patient that would show this form of treatment to be of any great benefit.

Types

Our series consisted of two main types and one unusual type. The majority of the childhood group fell into the category of progressive muscular dystrophy, with average age of onset between infancy and 5 years, rapidly progressive in nature and incapacitating the patient by the age of 10 to 12 years. In comparison, the facioscapulohumeral type, with average age of onset either in adolescence or early adulthood, 10 to 17 years, apparently equally distributed among the sexes, is much more favorable in prognosis and much less disabling, because it is slowly progressive and contractures do not develop.

There was an unusual type, a myotonic dystrophy in a white man. This patient is still ambulatory, but cannot endure heavy work without excessive fatigue.

Signs and Symptoms in Children

In general, the signs which we observed in children were chiefly the typical waddling gait, even in the early stages when the patients were still ambulatory, in which the feet were slapped

Read before the Florida Medical Association, Eightieth Annual Meeting, Hollywood, April 28, 1954.

*Protein Hydrolysate, containing Amino Acids, Vitamins and Minerals, Walker Laboratories, Inc.

**Rubrafolin Capsules, containing Vitamin B_{12} and Folic Acid, R. R. Squibb & Sons.

down alternately in front of the body, with a waddling scissors-like gait, in which one hip was rolled ahead of the other, in an effort to propel the body forward. Most of these ambulatory patients could not walk more than 100 to 200 feet without falling. This, in itself, was of diagnostic importance, in that often it was the first sign that was noticed either by the teacher at school or by the parents.

It is also to be emphasized that there is no pain in this disease and there is no disturbance of the peripheral sensation.

Even the early cases, in childhood, showed the exaggerated lordosis and the characteristic hypertrophy of the axial muscles, chiefly in the gastrocnemius and the gluteus, with progressive involvement of the legs, thighs, involvement of the back muscles and upper extremities, shoulders, and deltoid groups.

Only 4 of this childhood group were still ambulatory. The remainder of the children, averaging 12 to 13 years of age, were incapacitated and spent most of their time in bed or in wheel chairs. Even in the early cases in the childhood group the patient showed Gower's sign, which is described as that when a child, lying on his back, attempts to arise, turns over on his abdomen, rises to a kneeling position and, by laborious process, climbs up his thighs, to gain the upright position.

Neurologic examination gave essentially negative results, except for hypoactivity or even absence of the deep tendon reflexes.

In 2 of the childhood cases, we noticed a definite trend towards obesity as the child approached adolescence. The children in these cases had a body build characteristic of Fröhlich's syndrome with excessive deposits of adipose tissue in the buttocks and pectoral region.

Signs in Adults

In the adult group we noticed, usually, either involvement of the scapular muscles, with winging of the scapula, or an atrophy of the pectoral group of muscles, with later involvement of the muscles of the arms and forearms. This form of the disease is slowly progressive and eventually may involve the muscles of the lower extremity. In addition, this form of the disease is frequently misleading, giving rise to mistakes in diagnosis.

Pathology

The muscles affected by dystrophy are pale, firm and shiny. Microscopically, there is a fatty infiltration between the muscle fibers, gradually replacing the muscle fiber itself. In the later stages of the disease, the muscular tissue is almost completely replaced by fat and fibrous tissue, in with the muscle resembles a lipomatous mass. It is this lipomatosis of the connective tissue that causes the bulging of the muscle and makes it appear that the muscle itself is enlarged.

Roentgen Evidence

There have been numerous reports in the literature of bone changes associated with this disease. They, however, are not definitely pathognomonic for this disease and are found in other diseases in which there is chronic muscular wasting.

In several of the cases there was evidence of thinning of the cortex, with narrowing of the medullary canal. Soft tissue radiographs showed characteristic atrophy of the muscle bundles (fig. 1). Roentgen studies, however, are of limited value in this disease.



Fig. 1.—Soft tissue radiograph showing advanced case of muscle bundle atrophy of legs.

Laboratory

We noticed a significant trend in the blood nonprotein nitrogen and urea nitrogen (figs. 2 and 3). As the disease progressed, the values for nonprotein nitrogen and urea nitrogen were elevated above normal. The values for urine creatine and creatinine were proportionate (fig. 4).

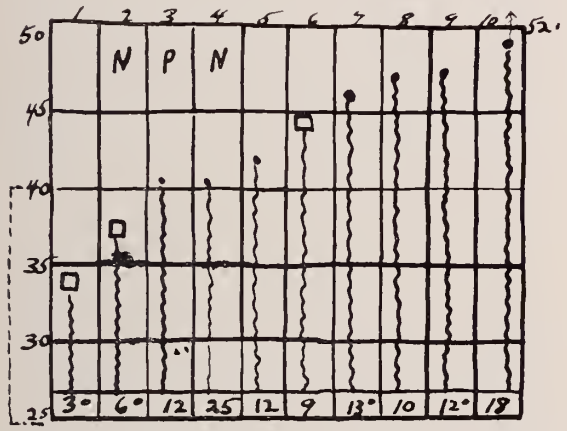


Fig. 2.—Blood nonprotein nitrogen values (fasting) in 10 unselected cases in order of clinical progression.

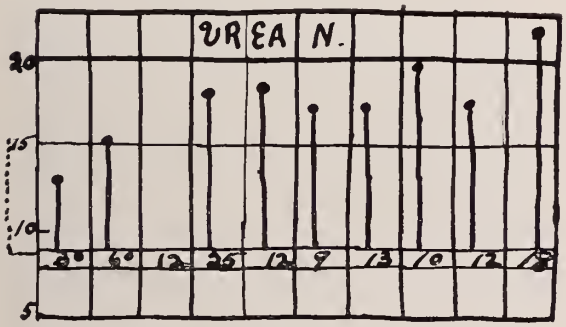


Fig. 3.—Blood urea nitrogen values (fasting) in 9 unselected cases in order of clinical progression.

In 1 case the serum bilirubin was elevated, with 4 plus cephalin flocculation. In 2 of the cases there was intermittent acetonuria, the etiology of which was not determined.

In 2 of the far advanced cases, in which the average age of the patients was 18, there were low serum protein values, averaging 5.65, with normal albumin-globulin ratios. It was in this group that the pseudohypertrophy phase disappeared and the atrophic phase with severe contractures became more pronounced. Our problem then became one of maintaining normal nutrition and body weight, which we were unable to do.

Results of Physiotherapy and Bracing

In the adult form of the disease, physiotherapy is usually not necessary. The disease, in most cases in our series, if it started late and was not a carry-over from childhood, did not require physiotherapy, as contractures do not develop in this form of the disease. Exercise and postural training were carried out, but active exercise was not carried out to the point of fatigue.

In the childhood group, we were unable to accomplish a great deal because the majority of our cases were already far advanced. There were only 4 of this group that we could attempt to salvage.

Mild contractures were corrected by means of wedging casts, and after correction leg braces were applied. The braces prevent the re-formation of contractures but, if they are neglected and the braces left off, the contractures tend to re-develop. Lordosis supports are also most helpful.

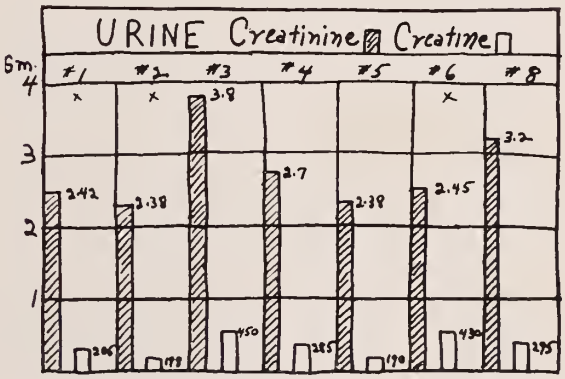


Fig. 4.—Urine creatinine and creatine values, 24 hour specimens, creatine in milligrams and creatinine in grams, in 8 cases.

Physiotherapists had difficulty in stretching the tight muscles because most of the children with this disease have low thresholds of pain and do not cooperate with the therapist. The weakened muscles in which contractures were developing were splinted at night, with night splints made of plaster or other suitable material. The child was taught how to sit properly in a wheel chair in order to prevent the deforming action of gravity and prevent the serious contractures of the feet, which develop as a result of faulty posture and gravity.

The use of slings and self-help gadgets, to assist weakened muscles and encourage the functional movements and the activities of daily living, such as eating, dressing, brushing teeth and washing the face, help a great deal in rehabilitation of

these children. Physiotherapy, however, is of no value without the cooperation of the parents or relatives, who, ideally, should carry on the program at home, twice a day, five days a week.

Summary and Conclusions

The Van Meter regimen has not produced any effective result in our cases of muscular dystrophy.

Early bracing, plus physiotherapy and the use of wedging casts, to correct early contractures, will, to a certain measure, correct the serious deforming aspects of this disease. It is too early, in our series, to determine if it will be of permanent value.

The added weight of obesity, which occurs near adolescence, throws added strain on a body which already has a weakened muscular system. The diet should be low in fat and high in protein, with added vitamin supplement. The child should be watched carefully towards adolescence, to maintain an average body weight.

Elective surgical procedures should be avoided, if possible. Respiratory infections may also cause serious complications in these cases of dystrophy.

Surgical release of contractures of the hips, knees and tight heel cords has been tried in the past and has been of no benefit. In fact, the period of inactivity occasioned by the surgery seems to increase the progress of this disease.

A complete social history study was made in our series of 20 cases by a trained social worker. As a result of these studies, it was found that, in several cases, the child was unconsciously rejected by the parents. It was also found that none of these patients had ever been braced or had ever had any corrective appliance or device. In most cases, it was found that the physician was satisfied with just making the diagnosis. In many cases, the diet was found to be inadequate.

Therapeutic nihilism has no place in modern medicine. A patient with this disease, especially a child, has the same right to the benefits of a remedial program, proper diet, home nursing and proper education as any patient with a severe physical handicap. It is towards this ideal that we should strive for the benefit of the patient and society in general.

References

Abramson, A. S.: An Approach to the Rehabilitation of Children with Muscular Dystrophy, New York, Muscular Dystrophy Association of America.

Boshes, L. D.; Terry, W. S., and Jessup, R.: Dystrophia Myotonica (Myotonia Atrophica), with Report of Case, U. S. Nav. M. Bull. 46:1865-1878 (Dec.) 1946.

Brown, M. R.: Incidence and Heredity of Muscular Dystrophy, Study of 71 Patients Admitted to Massachusetts General Hospital, New England J. Med. 244:88-90 (Jan. 18) 1951.

Bruny, S. J. R., and Frankel, A. L.: Pseudohypertrophic Muscular Dystrophy; a Case Report, Ann. Int. Med. 35:1149-1157 (Nov.) 1951.

Fagin, I. D.: Dystrophia Myotonica; Report of Two Cases, with Associated Hyperostosis Frontalis Interna in One, J. Michigan M. Soc. 45:500-503 (April) 1946.

Frantzell, A.; Hagberg, B., and Söderhjelm, L.: Werdnig-Hoffmann's Progressive Muscular Atrophy. Creatine Excretion Following Vitamin E Treatment and Muscular Radiography, Upsala lakaref. förh. 56:209-223, 1952.

Milhorat, A. T.: Studies in Diseases of Muscle; Progressive Muscular Atrophy of Peroneal Type Associated with Atrophy of Optic Nerves; Report on Family, Arch. Neurol. & Psychiat. 50:279-287 (Sept.) 1943.

Milhorat, A. T.: Recent Advances in Therapy of Diseases of Muscle, M. Clin. North America 24:769-775 (May) 1940.

Ramsey, R. H., and McCarroll, H. R.: Problem of Muscular Dystrophies, J. A. M. A. 150:659-662 (Oct. 18) 1952.

Tyler, F. H., and Stephens, F. E.: Studies in Disorders of Muscle; Clinical Manifestations and Inheritance of Facioscapulohumeral Dystrophy in Large Family, Ann. Int. Med. 32: 640-660 (April) 1950.

Tyler, F. H., and Stephens, F. E.: Studies in Disorders of Muscle: Clinical Manifestations and Inheritance of Childhood Progressive Muscular Dystrophy, Ann. Int. Med. 35: 169-185 (July) 1951; Correction 35:1164 (Nov.) 1951.

Tyler, F. H., and Perkoff, G. T.: Studies in Disorders of Muscle; Is Progressive Muscular Dystrophy an Endocrine or Metabolic Disorder? A. M. A. Arch. Int. Med. 88:175-190 (Aug.) 1951

Van Meter, J. R.: Progressive Muscular Dystrophy, California Med. 79:297-299 (Oct.) 1953.

1105 Huntington Building (Dr. Burch)

Discussion

DR. ROBERT P. KEISER, Coral Gables: I should like to commend Dr. Burch for gathering this group of cases together from our area of South Florida for this type of a study. We who work with crippled children quite a bit have seen these cases from time to time over a period of years, but never have taken the time or made the effort to gather them together for such a study as Dr. Burch has made. He has shown among other things that the premature and ill-advised publicity of a cure which came out of California not too long ago has little or no basis in fact. I feel very strongly, and I think most of us do, that this type of publicity is becoming all too frequent. It does much more harm than it does good. It creates a furore among the afflicted patients and their parents, and we are deluged with requests or even demands to give them the cure. If we hesitate to start treatment with a remedy that has been publicized in the newspapers, the patients criticize us. If we go ahead and give it, sometimes at great expense to them, they are disappointed nine times out of 10 in the end result, and nobody is benefited.

It is important in handling these cases to differentiate between the myopathies and the neuropathies. Of the myopathies there are two large groups, the pseudohypertrophic type of childhood and the facioscapulohumeral type. In the neuropathies the two predominating groups that we see, particularly in children, are the peroneal type of Charcot-Marie-Tooth and the Werdnig-Hoffmann type in the infant. Differentiation is not important in that we can cure any of them, but it is important because the prognosis is different, the clinical course is different, and the treatment is altered.

In the pseudohypertrophic type of childhood, the onset is early in life, fairly rapidly progressive and few of the patients reach adult life. In the scapulohumeral type, the onset is usually in adolescence, little treatment is necessary, and many of the patients live to a ripe old age.

In the neuropathies, of the two main types the Charcot-Marie-Tooth type is usually slowly progressive, whereas the Werdnig-Hoffmann type in infancy is usually rapidly fatal. I agree with Dr. Burch that in treating these patients we must avoid, particularly in the pseudohypertrophic type, putting them to bed for long periods of time either for corrective cast therapy or for surgery. They do poorly, they degenerate more rapidly once they are in bed, and following surgery, as he has pointed out, the deformities recur with disgusting regularity.

On the other hand, in the peroneal type of Charcot-Marie-Tooth, if it is slowly progressive and the usual foot deformities develop that we see in this condition, the patients can be materially aided by foot stabilization and perhaps tendon transplant if such are available to balance the foot.

In following cases of these types we have quite a bit of difficulty with the parents. We have found that these difficult parents fall into two large groups. The first group, on learning that their child has a progressive incurable disease, will reject him, put him in a corner and forget about him other than perhaps to feed him and just maintain life. The other group is just as bad. They are not willing to accept the fact that we have no cure for this disease. They will exert no effort on their part to help us treat the patient in the home; rather, they will run from pillar to post, accepting any type of quackery, injections and medication, spinal manipulations, et cetera, which somebody holds out as a cure. As the result, the child suffers because of lack of what little we could do for him on an intelligent medical regimen.

I also agree with Dr. Burch that these patients, particularly the children, are entitled to every bit of help, that we can give them even though we cannot cure the disease. I do think, however, that we as physicians are obligated to ascertain as best we can that the groups usually organized by the laity to help these patients are really unselfish in their motive and that they use the publicly collected funds they gather intelligently medical-wise. Too often I am afraid these funds are utilized and sift away for administrative cause, publicity, or to satisfy some selfish person who insists on spending large amounts of money uselessly for the hopelessly far advanced case.

Dr. Richard E. Strain, Miami: Dr. Perlmutter had to be out of town for another meeting. I am Dr. Strain of Miami, and he asked me if I would pinch hit for him in this discussion. I think it is well that Dr. Burch has directed our attention to the fact that muscular dystrophy is a problem here in South Florida. We are pretty well familiar with the fact that the cause of muscular dystrophy is as yet unknown. If we stop to think, we recognize that a muscle is really a tiny complicated machine for moving parts of the body, and we usually think of it as being under the control of the nervous system so that we frequently look to the nervous system when there is really some pathologic change in the muscle which is the cause of the trouble. The essential pathologic state of muscular dystrophy, as far as we know, is still thought to be in the muscle. The muscle fibers swell up to large size, the striations break up, the sarcoplasm of the muscle becomes homogenous and glassy in appearance, while large vacuoles of fat appear in the muscle so that there is a large strong-appearing bulky muscle which is really weak and unable to perform its normal function.

As Dr. Keiser said, the dystrophy should be distinguished clinically from the muscular atrophies and we can distinguish them on a clinical basis, as he suggested, by the fact that the dystrophies begin in early life and they are usually hereditary and familial in their origin. The prognosis of the dystrophies so far as life is concerned is usually better. In addition, clinically, the trunk, the pelvic and the shoulder girdle muscles are involved before the distal portion of the extremities in the dystrophies. If one observes these muscles carefully, in the dystrophies there are no fascicular twitchings as there are in the muscular atrophies, and there is no reaction of degeneration in the dystrophies.

It is not always easy to tell in the early stages whether a child may have muscular dystrophy. Parents frequently become greatly concerned when it is thought their child may have a progressive disease of unknown origin with no cure available. A good test is to have a child placed on his back and ask him to stand. Normally a child will flex his trunk; he will bend his knees and with a push of the arm get up. A dystrophic child, on the other hand, will turn on his abdomen; he will push his trunk off the ground so that he is in a kneeling position, then lift his trunk with his hands and may crawl up his trunk with his hands, so getting to the erect position. As the pictures presented by Dr. Burch showed, in dystrophies the trapezius, pectorales, latissimus dorsi, rhomboid, gluteal, quadriceps femoris and posterior spinal muscles are the ones most commonly involved in the dystrophies.

Dr. Keiser mentioned the fact that there are several types of dystrophy, and these differ really only in their age of onset in the muscles involved. The pseudohypertrophic type, as he mentioned, has its onset usually in the first five years of life, and in this type the calf muscles become large and doughy while the thighs usually become atrophic. The progress is rapid. A few of the patients reach 20 years of age. The facioscapulohumeral type of Landouzy-Déjerine is the common type that occurs between the age of 12 and 14. Dr. Burch showed patients with this type of dystrophy with their lordosis, winging of the scapula and facial involvement. Then there is another group of sporadic cases in which the disease occurs in later life. Only a small group of muscles is involved, and the progress of the disease is much slower.

In any chronic wasting disease of a progressive nature in which the real cause is unknown, the most important objective, as Dr. Burch emphasized, is to improve the efficiency of the remaining muscular function. It is in this field that the orthopedists play their chief role. When this is coupled with a sympathetic interest in the patient's problem, then scientific therapy is no longer cold, the patient's morale remains high, and his progress and happiness in life are much greater.

The Program of the

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Epilepsy

WILLIAM H. MCCULLAGH, M.D.
JACKSONVILLE

This paper is being presented with the hope of stimulating more interest in convulsive states. It contains some of the observations my associates and I have noted of convulsive phenomena occurring in Duval County from 1948 through 1953. The county has a population of approximately 325,000. We were unable to obtain definite information as to how many persons with convulsive states there are in the county; however, during this six year period about 800 patients were admitted to the five general hospitals because of convulsions. There were slightly more males than females.

The majority of the patients admitted to the hospitals because of convulsions were children. The most common secondary diagnosis in these cases was fever due to an infection of the upper part of the respiratory tract.

During this six year period we made approximately 1,300 neurologic examinations and electroencephalographic tracings on patients in our office and slightly over 500 in the clinic of Duval Medical Center. The majority of these patients had convulsive attacks which were recognized by the family or the referring physician.

Fallacies about convulsive phenomena were not uncommon. Ignorance and superstition were frequently reflected in the history of these patients, relatives believing that because of the behavior there is something about the seizure that is caused from or by the devil, or that the patient has sinned and that he is being seized by the devil for his wrongdoing. Some of the patients believed that if another convulsion occurred, they would die. This fear varied considerably. One patient who lived near my office was kept confined to his bed and heavily narcotized with phenobarbital because the mother believed that the eleventh seizure would kill him. With the aid of the Vocational Rehabilitation Association we were able to dispel her delusion and work out a better anticonvulsant regimen so that the patient is now gainfully employed.

Read before the Florida Medical Association, Eightieth Annual Meeting, Hollywood, April 28, 1954.

Parents and teachers are at times apt to be overly solicitious of a child who has a low convulsive threshold and will so restrict the child's activity that when he reaches adulthood, he is not well equipped for life and continues to be an adjustment problem, although his seizures have stopped.

We learned that "epilepsy" was a bad word and meant to the relatives that the patient had a horrible disease that would lead to mental deterioration and institutional placement. Our observations indicate that this concept is not true. From the years 1948 through 1953, according to the records in the County Judge's office, there were only 24 patients committed to the State Hospital out of 1,128 total commitments from the county. Among those, there was a secondary diagnosis of brain tumor, cerebral accident with hemiplegia, and convulsive state following brain surgery.

Prognosis

In our experience, the most benign of convulsive states are febrile seizures in children with a positive family history and electroencephalographic findings of bursts of symmetric delta activity present in all leads. Nearly all of these patients recover. The next best prognosis is in the petit mal with the classical 3 per second spike and dome dysrhythmia. In these cases there is frequently a family history of migraine. These two groups should be termed more "pure epilepsy" or idiopathic epilepsy.

In the childhood group with the less favorable prognosis are those patients with convulsive disorders associated with cerebral birth injuries and encephalitis. In some of these patients there are definite positive neurologic findings indicative of the organic brain disease, though the greatest aid is obtained from the electroencephalographic findings. These tend to show asymmetries in the brain wave pattern, focal activity and a spike and dome wave of 2 per second frequency (the petit mal variant). The prognosis in this instance depends on the severity and progress of

the organic brain disease, and should be more properly labeled symptomatic epilepsy. Naturally, in some of the cases in this organic group the patients do become institutionalized, though even in this group it is still important to use all the anticonvulsant medications at our disposal. It is difficult to get follow-ups on these patients. The fact that less than 1 per cent are rejected for military service on account of epilepsy would seem to indicate that most of them recover.

It was amazing to me, in the beginning of this work, to find that the patient with grand mal, particularly in the adult group, occasionally had a normal electroencephalogram in the interseizure period, though in most of these grand mal patients we were able to demonstrate bursts of delta and spiking, and, in some, the classical bursts of high amplitude spikes. We learned, too, from this experience with convulsive phenomena, that a seizure occurring in a middle-aged person was likely to be due to some organic brain disease, and, unless a generalized classical convulsive dysrhythmia was demonstrated, additional diagnostic studies, including pneumoencephalograms, should be made.

Electroencephalography has also proved helpful in the management of cases classified as hysterias. We have found that a number of patients with hysterical outbursts and hysterical seizures actually had a cerebral dysrhythmia. They were benefited by anticonvulsant medication. We also have found that a few persons with "hot tempers" had dysrhythmias, and they also were benefited by anticonvulsant medication.

Treatment

As was indicated in the early part of the paper, therapeutic conferences with the parents and relatives are actually more important than the anticonvulsant drugs. Correcting some of their distorted notions about seizures and about epilepsy is extremely helpful. Encouragement and reassurance are most important in these cases. Having the patient live as full a life as is compatible with his condition is good, and, with few exceptions, it is best to allow a child to do everything the other children do. It is helpful to explain to the patient factors that further lower the convulsive threshold, such as overfatigue and exhaustion from disease and infection, and irregularity in habits of eating and sleeping, bowel function, et cetera. It is also important for the patient to abstain completely from the use of alcoholic beverages, restrict beverages containing caffeine and avoid the excessive drinking of water.

In small children barbiturates, Mebaral, Butisol and Dilantin, are the safest and best, though in recent months our oldest anticonvulsant, bromide, is gaining some popularity for use in the young children.

If the patient is of school age or in college, it is better to attempt to control his seizures with Dilantin or Mesantoin. If a barbiturate is necessary, use Mebaral instead of phenobarbital or bromide, as the latter two drugs have been shown to lower the learning capacity of the individual.

In the petit mal, Paradione and Milontin are the better drugs, though there are still some workers who believe that phenobarbital should be given.

In the adult group, with nocturnal seizures, or grand mal, which is the more common, we frequently find that a combination of phenobarbital with Dilantin is one of the safest to use over a long period of time. Our experience, too, has taught us, in order to gain the confidence of the patient, it is well to use large doses of the medication, or combinations thereof, to bring the attacks under control, even to the extent of reaching toxic level. If Mesantoin is used, and we have found in some cases that it worked better than other combinations, blood counts should be made at fairly frequent intervals. This drug should not be prescribed unless the patient can be given follow-up care.

Illustrative Cases

Now, I should like to show a motion picture illustrating first an unusual convulsive case, in which apparently a flicker phenomenon was the stimulus to induce the seizure.

Case 1.—T. L. W., a white man, aged 27, had a history of having grand mal convulsive attacks, occurring only after reading 10 to 15 minutes. After reading this period of time, he has twitching of his jaw and throat muscles, which is attended with delta activity, thought by us not to be artifactual. This preceded the onset of the grand mal seizure. He did not have a grand mal seizure at the time we were running these pictures, but they show the prodromal symptoms of the twitching. The only other time that he has had an attack was a few months ago while driving in the late afternoon with shadows across the road from a pine thicket making a flickering light. We concluded that, possibly, it was a light flicker

associated with the eye movements that induced his attacks.

Case 2. — The A children are shown; 3 male children have seizures and a female does not. The first picture shows the oldest, now adult in age and free of seizures, though he quickly shows a dysrhythmia on hyperventilation. The other tracings show the classical petit mal dysrhythmia in 2 of the other children who were not available to have their pictures made. The female child shown has no seizures and is only slightly dysrhythmic. Her electroencephalogram borders on the abnormal.

Case 3. — Here are 4 year old Negro twins, whose mother has a history of migraine. One of the twins has classical petit mal attacks with a 3 per second spike and dome dysrhythmia. The other shows no dysrhythmia, even after prolonged hyperventilation.

Case 4. — J. A., a white woman, aged 26, has a large left-sided brain tumor, partially removed surgically. The tracing shows asymmetry, delta activity, et cetera.

Case 5. — E. K., a white boy, aged 4, has seizures both of the grand mal and the petit mal variety. The electroencephalogram shows bursts of high amplitude slow waves with interspersed spike forms of 3 to 4 seconds' duration. The seizures are fairly well controlled by medication.

Case 6. — A. R., a white boy, aged 12, had recurrent "day-dreams," as his mother called them, when he would go into a trance with a little flickering of his eyelids several times a day. The tracing shows the classical 3 per second spike and dome dysrhythmia. This cleared up in about three years, and he now has a normal tracing.

Case 7. — B. B., a white girl, aged 4, had two grand mal seizures associated with fever, preceded by nausea, weakness and irrational talk.

The last portion of the motion picture shows a chart listing the anticonvulsants.

Anticonvulsants

Bromides — Ketogenic Diet
Fluid Restriction
Barbiturates: Phenobarbital,
Luminal Sodium, Pentothal Sodium,
Dilantin Sodium (diphenylhydantoin sodium), capsules grains ½, 1½,
Mesantoin (methylphenylethyl hydantoin),
Paradione (paramethadione) and
Milontin (N-methyl-alpha-phenylsuccinimide)

Summary

A study of cases of epilepsy observed in Duval County during a six year period is presented. Prognosis and therapy are discussed, and emphasis is placed on the value of therapeutic conferences with the parents and relatives of the patients to correct their erroneous ideas of the disease. Illustrative cases are cited, and a chart listing anticonvulsants is given.

709 Lomax Street.

Discussion

DR. JAMES G. LYERLY, Jacksonville: I greatly enjoyed Dr. McCullagh's paper and his motion picture. I want to thank Dr. McCullagh for bringing this subject before the state society at this meeting because it is one of great importance. A large number of persons are afflicted with convulsions, and too frequently these patients are said to have epilepsy. The word epilepsy carries with it a certain amount of stigma, and many persons are subjected to mental suffering just from having this diagnosis made. For that reason I want to be sure that the patient has epilepsy. By that I mean repeated convulsions in spite of adequate treatment; that is what I would call epilepsy. If a patient has occasional convulsions, does not have them repeatedly, and treatment will stop them, I do not think we ought to refer to that patient as having epilepsy. I prefer the term convulsive disorder or convulsive state in cases of that type.

After all, if the patient really has epilepsy or this convulsive disorder, he is handicapped in many ways. It is not safe for him to drive a car; in fact, he should not drive a car, or do any climbing, or go on the roof of a house to fix it because serious injuries and damage could come from going on a roof or doing any climbing or even driving a car. I have seen serious accidents from all those occupations. Also, the patient is handicapped about going into society and mixing with his friends. He is more or less ostracized from society. Children also are handicapped in going to school and getting an education. So it is seldom that a patient with epilepsy can carry out a full life. As I see it, it should not be said that a patient who has one or two convulsions and may not have any more has epilepsy. Many persons have a low convulsion threshold and can have a convulsion on slight stimulus from some toxemia or fever such as a cold, sore throat, or pneumonia. We have all seen convulsions with fever, especially in childhood and when the patient is not in that toxic state, he may never have another convulsion. The same is true for a slight blow on the head or slight trauma of the head with or without temporary unconsciousness. The patient may be brought into the hospital with a convulsion or even a jacksonian convulsion and may never have another convulsion. I think everybody can have a convulsion if the proper stimulus is applied. Some persons have a lower convulsion threshold than others, and it is easier for one person to have a convulsion than for another.

I think that every patient who comes to a doctor with a history of convulsion — one or more convulsions — should have a thorough examination for organic pathologic change. There are many causes for convulsions. The term epilepsy or convulsion designates only a symptom. It does not describe the true pathologic condition that may be present in the nervous system. We ought always to make thorough studies to rule out organic pathologic changes in the nervous system. From the neurosurgical standpoint, we are naturally interested in organic pathology in the nervous system. We know that brain tumors, brain abscesses, subdural hematomas, localized cerebral scars, cranial defects with adherent scars of the dura and cortex all can produce convulsions. Sometimes the convulsions have focal manifestations, and in studying the case from the clinical standpoint we should obtain a thorough history in trying to determine whether or not there are focal manifestations. Most of the patients probably should be hospitalized for a complete history, neurologic examination including roentgenograms of the skull, spinal fluid studies, all the laboratory studies, and an

electroencephalogram in most cases. In a certain percentage, a fairly large percentage, I think, if we suspect organic pathologic change, the patient should have air studies or a pneumoencephalogram.

Dr. McCullagh makes about all of our electroencephalograms in Jacksonville, and I want to thank him for helping us out in studying these cases. Sometimes the electroencephalogram will show up a focal discharge at some one point indicating a local lesion, in which case the patient probably should have air studies, to rule out a brain tumor and lesions of that nature. I think the electroencephalogram is also of importance, especially in the medicolegal cases of convulsion to rule out a functional seizure of some kind such as hysteria. It is a great aid to differentiate functional convulsions or hysteria from organic or true convulsive seizures. I agree with what Dr. McCullagh said about the treatment. I think Dilantin and phenobarbital are probably the best drugs, but of course there are other drugs that can be used, too.

Dr. Hugh A. Carithers, Jacksonville: Epilepsy, the ancient disease, is now being called the "hopeful disease." The last 10 to 15 years has been an era in which effective treatment of this disease has advanced dramatically so that now physicians can offer much more than merely diagnosis and prognosis to the convulsive patient. New therapeutic agents, both medical and surgical, are still in the process of development. Since the founding of pediatrics as a specialty, there has been considerable emphasis on the treatment of a child with a disorder as a whole rather than on the treatment of the disorder alone. The use of the whole child concept is particularly important in the care of the epileptic child who has difficult psychologic problems whether his condition is mild or severe. The patient should be encouraged to lead a full life with the imposition of restraint only when absolutely necessary to assure body safety.

The attitude of the adults who come in contact with the epileptic child is of great importance. Helping parents to understand the difficulty in all its ramifications may take hours of time, but it is the responsibility of the physician and it is worth while for his patient. Children with seizures do well in public schools usually, unless there is accompanying mental deficiency. It is surprising how calmly youngsters will accept the second convulsion of one of their schoolmates provided the teacher was perfectly calm and matter-of-fact about the first one. Of course the aim is to prevent convulsions altogether, but in some cases it cannot be done.

I would not undertake the care of an epileptic child, even when the history seems clear, without the diagnostic aid (as to severity and type) and the therapeutic hints offered by an electroencephalogram. Repeated tracings are of value in evaluating the effective drugs and studying changes in the basic convulsive aptitude or pattern. One out of every 15 children under 5 years of age may be expected to have a convulsion accompanied by fever. All such children do not need to have an electroencephalogram, but when the convulsion is severe or difficult to control, or when the convulsions recur, such a tracing along with a thorough work-up, as Dr. Lyerly just recommended, is indicated. We are fortunate in having facilities for electroencephalography, and someone like Dr. McCullagh to interpret the tracings in our section of northeast Florida. Such facilities should be made available to all convulsive patients in the state, both adults and children.

Management of Hemorrhage from Esophageal Varices

Abbott Y. Wilcox Jr., M.D.
ST. PETERSBURG

Massive hemorrhage from esophageal varices is an alarming occurrence and occasionally taxes the therapeutic wits of the internist and the surgeon. It is believed that some type of operative procedure to relieve the hypertension in the portal system of vessels supplying the lower portion of the esophagus and upper part of the stomach is eventually indicated in properly selected cases. It is not my purpose, however, to discuss the surgical approach to this problem. Rather, I would briefly outline a practical medical approach to the problem of management of these cases during the acute critical bleeding phase.

This discussion is based on the 34 cases which were observed during the period from May 1950 to May 1953. In all of the cases the presence of esophageal and/or gastric varices was proved by esophagram, esophagoscopy, at operation, or at postmortem examination. In 28, or 82 per cent, of the cases the lesion was bleeding when the patient was admitted to the hospital or bled during the period of hospitalization, or a massive hemorrhage occurred as a terminal event.

Figures 1 and 2 are diagramatic sketches of blood vessel patterns found in 2 previously reported cases[1] and show two ways in which the esophageal and gastric veins may become dilated owing to portal hypertension. They both represent instances of extrahepatic portal obstruction. Figure 1 shows collateral shunting resulting from chronic fibrous peritonitis involving the splenic and pancreatic portions of the portal system. Figure 2 shows collateral circulation resulting from obstruction of the superior mesenteric vein due to chronic peripancreatitis.

Diagnosis

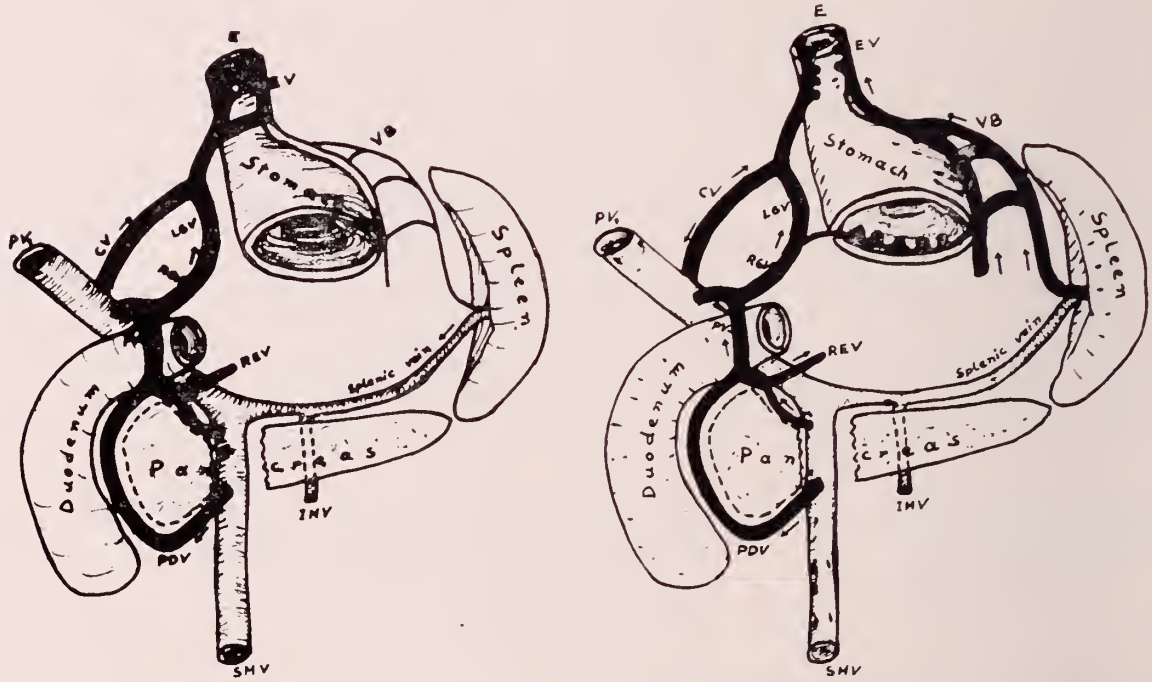
Essential to the proper management of these cases is of course a correct diagnosis. The age of the patient is of some help, but cannot always be relied upon. In this series the ages varied from 6 to 65 years at the time of the first hemorrhage. In general, however, the patients presented them-

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selves with their first hemorrhage in the fourth, fifth and sixth decades of life.

One should attempt to elicit a history of previous hepatitis, jaundice, cirrhosis, splenomegaly, pancreatitis, alcoholism, varices or peptic ulcer. It must be kept in mind that around 16 per cent of patients with cirrhosis have an associated peptic ulcer.

tract are used to this end. The result of the Bromsulphalein test must be evaluated in the light of hepatic dysfunction caused by anemia and anoxia. It is not detrimental to the patient to have an early esophagram and gastrointestinal series, provided the shock state is not too great, and it is advocated that roentgen studies be carried out as soon as possible after hospitalization of



Figs. 1 and 2.—Diagramatic sketches of blood vessel patterns showing two ways in which portal hypertension may cause esophageal and gastric veins to become dilated.

An emesis of voluminous amounts of bright red blood helps focus one's attention on the portion of the gastrointestinal tract proximal to the pylorus of the stomach. The signs of shock are usually present, that is, tachycardia, hypotension, pale clammy skin, sweating and tachypnea. The liver may be palpably enlarged, hard, nontender and nodular, but in a few cases it was at the costal margin or was not palpable. In addition, one may find palmar erythema, pectoral alopecia and spider telangiectasia, which are often associated with hepatic disease. The finding of splenomegaly is important.

Recourse to laboratory and roentgen studies is an aid in establishing an early diagnosis. In addition to routine blood counts, urinalysis, blood urea nitrogen and serologic tests for syphilis, the Bromsulphalein dye retention test, the prothrombin time, the thymol turbidity test, and radiologic screening of the upper part of the gastrointestinal

the patient. In addition to these measures, the Sengstaken tube has been found to be of value not only in helping to localize the bleeding site but also in the treatment of this condition. The use of this tube will be discussed more in detail later on.

Treatment

With the diagnosis established or even before, when the condition of the patient warrants, and it usually does, blood transfusions should be used freely, replacing each 300,000 red cell deficit below normal with one unit (500 cc.) of blood. The usual indications for transfusion, namely, rising pulse rate, falling blood pressure, falling hematocrit reading and red cell count, are kept in mind and are used as a guide for the use of blood. Often time does not permit the gathering of all these data; so one must rely on his clinical judgment, the color and amount of blood lost, and the condition of the patient in deciding on the amount

of blood to be used and the frequency of use. Plasma may be used to support the patient while blood is being readied.

In an effort to correct a prolonged prothrombin time (below 80 per cent of normal) vitamin K in large doses should be administered parenterally. Frequently little change is noted in the prothrombin time. My experience with vitamin K_1 oxide has been limited to 1 case and was disappointing.

In addition to these supportive measures, the use of the Sengstaken tube is definitely indicated to produce a tamponade effect in the lower part of the esophagus and cardia of the stomach. This tube, a three lumen one, with a gastric and esophageal balloon and a gastric tube, is superior to the two lumen tube, first because the third lumen permits the aspiration of the gastric contents to determine absence of or continuation of bleeding, and secondly nutritious liquids as well as water can be administered through the gastric tube, and if necessary barium can be given for roentgen study of the stomach and duodenum.

In figure 3, one sees the atomizer with the 1 per cent Pyribenzamine solution for use as a local anesthetic in the nose and throat, the Sengstaken tube, a 30 to 50 cc. syringe and a Tycos aneroid gauge, bulb and connective tubes. A suction machine is also needed, but not shown.

With the patient in the supine or, if possible, a sitting position, the nose and throat are sprayed with the 1 per cent Pyribenzamine solution.

After three to five minutes the lubricated Sengstaken tube with the balloons deflated is inserted into a nostril and passed into the stomach aided by sips of water. The gastric balloon is then inflated with 150 to 200 cc. of air and the tube leading to the balloon securely clamped with a Kelly hemostat. The tube is then withdrawn until definite resistance is encountered. The esophageal balloon is then connected to the manometer and air bulb by means of the glass Y tube and inflated with 40 to 90 cc. of air until a reading of between 20 and 30 mm. of pressure is recorded on the manometer. The tube is then taped securely to the nose and forehead.

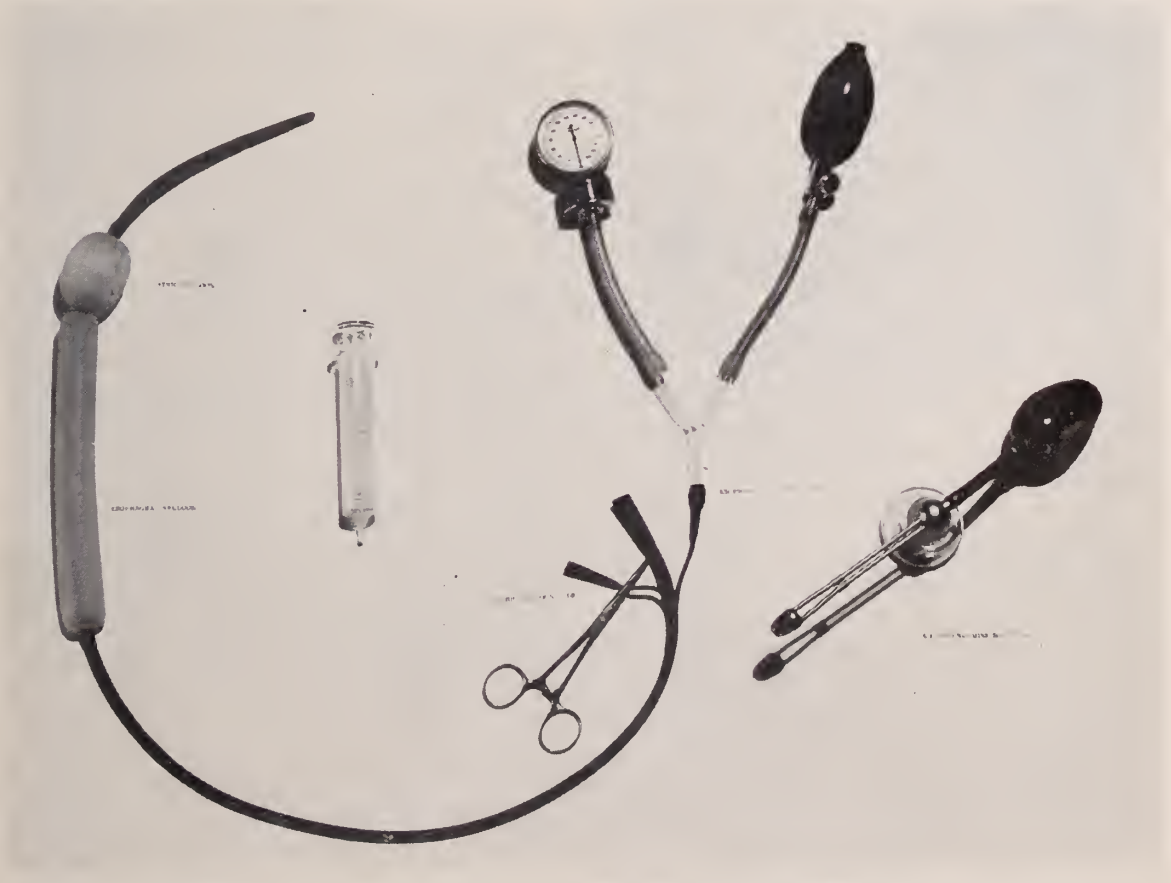


Fig. 3. — Shown here are the atomizer with the 1 per cent solution of Pyribenzamine for use as a local anesthetic in the nose and throat, the Sengstaken tube, a 30 to 50 cc. syringe, and a Tycos aneroid gauge, bulb and connective tubes.

The stomach is then aspirated so that all of the blood as well as air and swallowed water is removed from the stomach. During the aspiration, it is advisable to irrigate the tube frequently with at least 40 cc. of water to prevent blood from clogging the tube.

By portable x-ray a roentgenogram may be taken at this point to check the position of the tube.

Figure 4 is a diagramatic sketch of the tube in proper position, showing the relationship of the balloons to the cardia of the stomach, the esophageal gastric orifice and the esophagus.

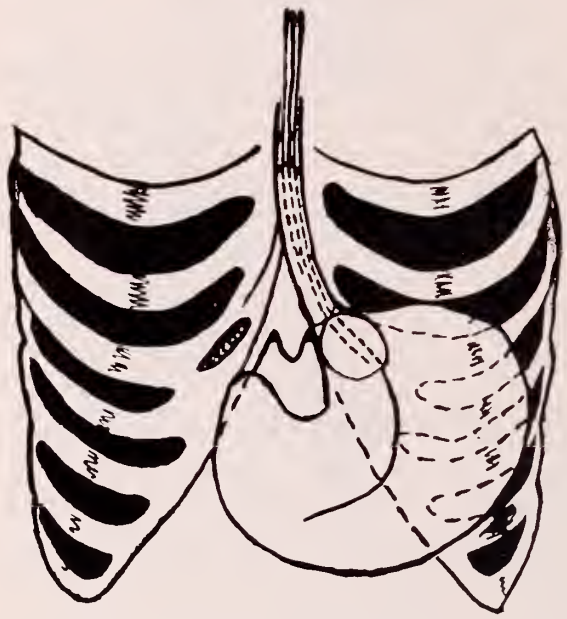


Fig. 4.—Diagramatic sketch of the Sengstaken tube in proper position, showing the relationship of the balloons to the cardia of the stomach, the esophageal gastric orifice and the esophagus.

The pressure in the esophageal balloon is then adjusted until bleeding ceases as determined by aspiration (usually 20 to 25 mm. of mercury as read on the manometer connected to one branch of the glass "Y" tube). When the balloon is in the proper position, the pressure will vary with cardiac pulsations and respiration movements. Contractions of the esophagus may raise the pressure to 70 mm. of mercury. If more than 90 cc. of air is needed to give an adequate pressure (namely, 200 cc.), one may be fairly certain that the balloon is well out of the esophagus and into the stomach and hence down too far. The pressure should not fall below 20 mm. of mercury as recorded on the manometer and should be checked every 20 minutes to be sure that no leakage has occurred.

The stomach aspiration tube is then connected to constant suction. The tube should be irrigated with 40 cc. of warm saline every half hour to help prevent the tube from being clogged with blood clot. Elevating the head of the bed tends to keep the stomach empty and to decrease nausea and gagging. Adequate sedation is essential. The use of Luminal sodium intramuscularly is recommended, and this may be supplemented with Demerol if necessary. It is not necessary to keep the patient unconscious, but a slight stupor is desirable at first. Regurgitation is usually due to two causes. The more important is lack of sedation, and the other is allowing the stomach to become filled. Bleeding should be stopped and the stomach can be kept free of blood once adequate pressure is maintained upon the esophageal wall. It has been stated by Warthen, Ross, Baker and Wissing[2] that "when tube is in proper position, it has always stopped massive bleeding from esophageal varices." If the tube should be regurgitated, it should be repassed immediately and without hesitation.

If, after the esophageal balloon is inflated to as much as 30 to 35 mm. of mercury, repeated aspirations from the stomach reveal bright red blood, it may mean the source of bleeding is from a coronary vein on the wall of the stomach. In this event, the patient is given additional sedative at once, the nasogastric tube is snubbed up more firmly and taped securely to the nose. Finally, with care to avoid retching, the stomach balloon is gradually inflated with more air. It may require a total of 300 to 400 cc. of air to arrest bleeding. If further bleeding occurs, the site of bleeding probably is distal to the area affected by the tube (that is, pars media or antrum of stomach, pylorus or duodenum).

The esophageal balloon should be kept inflated at the minimal pressure required to control bleeding, approximately 25 mm. of mercury, for at least 48 hours and then deflated for 12 to 24 hours to see if new bleeding occurs. If none occurs, then the gastric balloon may be deflated. The tube with the deflated balloons is left in place for another 24 hours. If at the end of this time no bleeding has occurred as manifested by clinical or laboratory findings or bloody aspirant, the tube is slowly and carefully removed. During the time

the balloons are in place, the patient must be kept dehydrated and can be given nutrition by intravenous or clysis fluids. Feedings can be given through the stomach part of the tube, 100 to 150 cc. per hour, keeping the head of the bed elevated and the patient on his right side.

It is important to emphasize that the patient is to swallow nothing, not even saliva, once the tube is in place.

After the tube has been withdrawn, the patient may be given clear fluids and slowly advanced to a soft diet.

Results

Contrary to the findings of Bennett, Baker and Baker,[3] no cases of erosive esophagitis or gastritis attributable to the use of the tube have been encountered. No posterior pharyngeal obstruction or failure of the balloon to deflate during removal has been observed. In 2 patients there developed a cardiac arrhythmia or a brady cardia when the esophageal balloon was inflated beyond the recommended levels. One patient had symptoms of substernal pain with radiation to the left arm suggesting anginal pain.

In the 28 patients who bled, esophageal and gastric tamponade was tried in 12, leaving 16 patients untreated by this means. Of the 16, 1 survived a mild hemorrhage and 15 died. Of the 12 patients in whom tamponade was used, 4 died and 8 survived the hemorrhage episode for which they were treated. Of the 4 deaths, one occurred in a fairly young person with cirrhosis in whom multiple petechial hemorrhages were found throughout the stomach and intestinal tract. The other 3 deaths occurred in patients who were moribund on admission and presented far advanced hepatic disease on pathologic studies. Of the 8 who were treated for the hemorrhage episode and survived, 3 are still living following surgery for portal hypertension; 1 expired 10 days after a portal caval shunt; 1 was sent to another hospital, but died before operation was performed; 2 others died following operations,[1] and 1 expired on his second admission before therapy was started.

Summary

A simple practical approach to the management of bleeding esophageal and/or gastric varices, which has been based on experience with 28 patients, 12 treated and 16 untreated, is presented.

Early diagnosis by means of bedside examinations, selected laboratory tests and early roentgen examination is stressed.

Restoration of blood volume by blood transfusion is essential.

When the results in the untreated cases are compared with the results in the tamponaded cases, it would seem that the use of esophageal and gastric tamponade by means of the three lumen, two balloon tube, helps tide the patient over a critical period and allows time for preparation for a specific surgical approach to the problem.

References

1. Wilcox, A. Y. Jr.; Bovill, E. G., and Olivetti, R. G.: Patterns of Collateral Circulation in Portal System Following Extrahepatic Inflammatory Processes, Gastroenterology 21:375-381 (July) 1952.
2. Warthen, T. A.; Ross, F. P.; Baker, D. V. Jr., and Wissing, E.: Management of Upper Gastrointestinal Hemorrhage, Ann. Int. Med. 39:241-253 (Aug.) 1953.
3. Bennett, H. D.; Baker, L., and Baker, L. A.: Complications in Use of Esophageal Compression Balloons (Sengstaken Tube), A. M. A. Arch. Int. Med. 90:196-200 (Aug.) 1952.

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President McEwan's Address

Eighty-First Annual Convention

First House of Delegates Meeting

St. Petersburg, Tuesday Morning

April 5, 1955

Bone Marrow Examination in Clinical Medicine: A Study of Five Hundred Cases

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Examination of the bone marrow has become universally accepted as a useful and practical procedure in diagnosis of diseases of the blood and blood-forming organs and in cases in which consideration of such diseases enters into the differential diagnosis. Clinical manifestations of blood diseases and disorders are not always characteristic. The peripheral blood picture does not always reflect the marrow architecture, and examination of the marrow occasionally offers the only method by which a diagnosis can be established. For these reasons the study of the bone marrow, subject to certain limitations, has become established as a valuable diagnostic tool in modern clinical medicine.

The purpose of this paper is (1) to review briefly some of the history of bone marrow aspiration, (2) to discuss technics of marrow puncture and some details of the preparation of slides, (3) to illustrate the diagnostic value of bone marrow examination by describing alterations in marrow cytology in some of the more common blood disorders, and (4) to discuss the practical, clinical indications and limitations of marrow examination from a study and classification of 500 cases.

Historical Aspects

Prior to about 80 years ago the bone marrow was regarded merely as a mechanical filler of the medullary cavities of bones. The concept of bone marrow as a functioning organ was first proposed by Newmann[1] in 1868 when he showed that it was the site of erythropoiesis. In the following year he demonstrated that it was also the site of leukopoiesis. Following Newmann's work, postmortem studies were made of the effects of various diseases on the bone marrow. The lack of correlation often apparent between the findings in the blood during life and changes in the bone marrow after death finally led to the study of bone marrow in living patients by means of surgical biopsy.

It was not until 1908 that Ghedini[1] biopsied living marrow from the tibia as a method of diagnosing malaria and leishmaniasis. Although the tibia is not a particularly suitable bone for marrow examination in adults, because it contains little active red marrow, it was nevertheless appreciated that the method yielded important diagnostic information in a number of diseases. This procedure was subsequently employed in the various stages of pernicious anemia by Zadek[2] in 1922 on the Continent and again a few years later by Peabody,[3] who introduced the method in the United States. Since tibial marrow in adults is usually hypoplastic and since the sternal marrow is more cellular and accessible, Seyfarth[1] in 1923 suggested trephination of the sternum for study of the marrow in both sections and smears. The use of small trephines was advocated somewhat later by Dameshek,[4] by Tuohy and Gillespie[2] and by Escudero and Varela,[2] and reports by these investigators did much to stimulate interest in the clinical application of bone marrow study. While the use of these trephines constituted only minor surgical operations, nevertheless the scar resulting from their use on the sternum was an important objection, particularly in women.

A far better method for obtaining sternal bone marrow, namely, by aspiration of the marrow through a spinal puncture needle, was first described by Arinkin[1] in 1927. The advantages of this new technic were soon manifest. It was simple. The only special equipment necessary was a sterile bone marrow aspiration needle. Permission was not required from the patient as for biopsy. Repeated punctures could be easily done, and better preparations were obtained by aspiration than by biopsy in most cases. This method of aspiration was rapidly recognized as one of great clinical and pathologic value and remains the method of choice today.

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Technic of Marrow Puncture

In general, bone marrow may be removed from the sternum, iliac crest, vertebral spinous process, rib or other marrow-forming bone by means of the aspirating needle, needle trephine or regular trephine. Aspiration from the sinusoidal spaces of the sternum is the most popular method.

A number of different types of bone marrow needles of various sizes and shapes are now available. My associates and I prefer a rather small bore needle (#18 gauge for adults and #20 gauge for children) of a simple design. With such a needle the cortex is often penetrated more easily, less discomfort is apt to be caused to the patient, and just as satisfactory marrow fluid is usually obtained as from some of the larger size needles.



Fig. 1. — Sternal puncture showing needle in sternum at level of third interspace. Any interspace may be used, but second and third are preferred.

Sternal Puncture (Fig. 1). — A satisfactory puncture site for the sternum is its midline at the level of the second or third interspace, although any interspace may be used. After preliminary disinfection, the skin, subcutaneous tissues and periosteum at the site to be punctured are carefully infiltrated with 1 per cent or 2 per cent procaine solution. The bone marrow puncture needle with stylet is thrust with a slight twisting motion at an angle of about 60 degrees through the anesthetized skin and fascia, then through the ventral plate of the sternum into the myeloid cavity. The needle is inserted until it is firmly lodged without support by hand. In adults this is usually not over three eighths of an inch from the position of the needle when a "give sensation" is felt as it enters the medullary cavity. When the needle is correctly placed, the stylet is withdrawn, a syringe is attached and the bone marrow fluid, consisting of a mixture of bone marrow tissue and sinusoidal blood, is withdrawn.



Fig. 2. — Iliac crest puncture (anterior view of right iliac crest, with patient lying on left side) showing needle in right iliac crest about 1 inch behind anterior superior spine (marked by cross) and 1 inch below iliac crest (marked by curved line).

Iliac Crest Puncture (Fig. 2). — The iliac crest also offers an accessible site where marrow puncture can be carried out easily.[5] For this procedure I prefer that the patient lie on his left side, although the supine position is also satisfactory. Any stiletted bone marrow needle may be used. The puncture site usually chosen by us is in the approximate vicinity of a point about 1 inch behind the anterior superior spine and about 1 inch below the iliac crest. The needle is directed at an angle of about 60 degrees to the plane of the ilium, being pointed downward and inward. As the needle is forced through the cortex with steady pressure and slight rotation, a distinct "give" is usually felt as the needle enters the medullary cavity. The stilet is withdrawn, a syringe is attached to the needle, and marrow fluid is aspirated in the usual manner.

Vertebral Spinous Process Puncture (Fig. 3). — Vertebral spinous process punctures were apparently first described by Heidenreich and Heidenreich[6] in an Argentinean article in 1936 and later by the Belgian, De Weerdt.[6] The Japanese had evidently been using spinous process puncture for a number of years before our medical officers in the Pacific learned of it. Preferred are the broad surfaces of the lumbar spinous processes, especially those of the third and fourth lumbar vertebrae, although the spines of the tenth thoracic to the fifth lumbar vertebrae can be used. The patient may be placed in a variety of positions, namely, lying on his side with knees drawn up as for spinal fluid puncture, sitting with lumbar vertebra made convex by

leaning forward, and lying prone. Of these positions, the side and sitting positions are preferred to the prone position. The needle is advanced with a rotary motion and firm pressure at a 90 degree angle through the skin until it is firmly fixed to the bone and a sample is obtained in the usual manner. The marrow cavity of the vertebral spinous process contains a more limited volume of marrow fluid as compared with that of the sternum. An adequate marrow specimen for cytologic study can be readily obtained, however, and it has been shown by Loge[7] that differential counts of marrow samples secured simultaneously from the sternum and from a lumbar spinous process correspond closely. Furthermore, Nordenson[8] and Vogel[2] have demonstrated that the marrow differential count is essentially similar in material aspirated from the sternum, vertebral spines, ilium and ribs.



Fig. 3. — Vertebral spinous process puncture showing needle in spine of third lumbar vertebra. The tenth thoracic to the fifth lumbar vertebra may be used but the third or fourth lumbar vertebra is preferred.

While the sternum is probably best adapted for routine marrow aspiration, the use of the iliac crest and vertebral spine as alternate sites may occasionally be advantageous in certain situations.[9] Such situations are as follows: when the patient is a young child and hence the sternum is shallow, when an attempt is made to find metastatic cancer cells by puncturing the bone region having greatest tenderness, when puncture of more than one bone is indicated because patchy involvement of marrow by a disease process is suspected, when irradiation of the mediastinal region has changed the bone marrow architecture of the sternum, and when the sternum is unusually tender. When dealing with a sensitive patient, one may choose a site other than the sternum so that the needle is not "near the heart," and less psychic trauma is likely to result from the procedure.

In terms of age groups, it has been our practice to choose the tibia in babies up to the age of 1 to 2 years, to select the iliac crest in children from 1 to 2 years to about 12 to 14 years, and routinely to employ the sternum in patients over 12 to 14 years of age unless a special situation suggests the more advantageous use of the iliac crest or vertebral spine.

So-called "dry taps" of the marrow are occasionally experienced in some hands. These may occur not only with the hypocellular marrows of hypoplastic anemia, myelofibrosis and myelosclerosis but also occasionally in the highly cellular marrows such as in certain cases of leukemia. It is my opinion that the term "dry tap" is actually a misnomer, provided the point of the aspirating needle is well within the myeloid cavity, since one always can aspirate some liquid material by using sufficient suction and slightly repositioning the needle while exercising patience. Such material usually provides at least some indication of the state of the marrow and may at times furnish the diagnosis.

That bone marrow puncture can be regarded as a safe procedure is attested by the fact that only a few isolated accidents have been reported although the procedure has been rather widely used over the past 25 years. Fortner and Moss[10] reported 2 deaths due to cardiac tamponade with laceration of the anterior wall of the pulmonary conus and penetration of the needle into the chamber of the right ventricle. Meyer and Halpern[11] reported 1 death thought to be a result of shock due to fear. Rosenthal[12] mentioned 1 death from cardiac puncture in an unusually large series. Two deaths from sternal puncture were reported by Breiteneckt[12] and one by Alder.[12] With proper obvious precautions and with adequate experience, puncture of the sternum and of other marrow bones is considered an entirely safe procedure.

Preparation of Marrow Slides

Fluid aspirated from the myeloid cavity of bone is usually composed of a large and unpredictable amount of sinusoidal peripheral blood in which bone marrow particles are suspended. Using the method of radioactive phosphorus-labeled red cells, Fadem and Berlin[13] showed that the fraction of the marrow aspirate that is peripheral blood varied from 61 to 96 per cent when as much as 1 cc. to 3 cc. was aspirated in 10 cases, while this portion was 47 per cent and 61

per cent when only 0.1 cc. and 0.2 cc. was removed in 2 cases. Berlin, Hennessy and Gartland[11] in another study demonstrated that this same fraction of aspirate that is blood varied from 36 to 99 per cent in 24 cases, with a mean of 76.5 per cent (plus-minus a probable error of 11.2 per cent). Moreover, marrow particles isolated from the aspirated fluid showed no radioactivity, thereby demonstrating that they are composed only of bone marrow tissue undiluted with blood. In view of these quantitative studies, attention has been directed anew to an evaluation of some of the available methods of preparing slides from aspirated marrow fluid.

Direct Smears of Aspirate. — This method, which consists only of transferring the aspirated fluid directly from the syringe to slides, is the simplest and the most widely used. No intermediate steps or processing of the fluid is involved. The syringe must be completely dry. The marrow should be aspirated immediately after the obturator is removed from the needle, and only gentle suction should be used. To minimize dilution of the marrow fluid with blood, only 0.1 cc. to 0.2 cc. of fluid should be aspirated since Segerdahl[15] showed that there is a decrease in the total nucleated cell count of this fluid in successive drops of marrow aspirate. It is necessary to smear the material promptly on the slides to avoid clotting in the syringe since marrow fluid usually has a rather high fibrinogen content. A common error is not making the smears sufficiently thin. Better smears are usually obtained when they are made by pulling coverslips apart rather than by the usual method of smearing one slide with the edge of another. By using coverslips thin smears may be obtained which show proper dispersion of cells with relatively little trauma to the cells. The smears may be stained with any one of the accepted methods, such as May-Grünwald-Giemsa or Wright's stain.

Marrow Particle Smears. — Since the "pure" undiluted marrow fragment or particle selected from the aspirate is recognized as the most valuable for diagnostic purposes, various methods have been devised for isolating and smearing these particles. A technic described by Propp[16] has recently given satisfactory results in our hands. The 5 cc. aspirating syringe is first rinsed with a sterile dilute solution of heparin sodium (containing 1 mg. of heparin sodium per cubic centimeter of neutral buffered saline), leaving about 0.05 of this solution in the syringe. Approximately 1 cc. of marrow fluid is then aspirated and the syringe inverted several times to mix the fluid with the heparin. If desired, several smears of the marrow fluid may be made directly from the tip of the needle to slides or coverslips. The marrow fluid is then spread upon a concave slide or watch glass which may have a paraffined surface. The small marrow fragments usually appear grayish, but may be red in certain anemias such as pernicious anemia and hemolytic anemia. One or two of these particles are picked up with a glass pipet and expelled on the center of a coverslip. The small amount of blood accompanying the particles is removed with the pipet. A second coverslip is then placed directly on the marrow particle. To start the spreading, it is sometimes desirable to exert slight pressure to squeeze the marrow particle or to pull the coverslips gently in opposite directions. When the material is well spread out, the coverslips are pulled apart in the usual manner, resulting in a thin, grayish smear of actual marrow on each coverslip. Similar smears may be made upon a glass slide of standard size by pulling the flat surface of another slide across the slide transversely at several places. If desired, the smear may be made in the usual manner by pushing the short edge of one slide forward against the flat surface of the other. The smears may be stained with any of the standard polychrome stains such as Wright's stain.

Recognizing the fact that the addition of heparin or any other anticoagulant to the marrow fluid makes more difficult the satisfactory staining of smears prepared from this fluid, some investigators prefer to prepare marrow particle smears directly from the unadulterated marrow fluid. In this modification of the method, the fluid is placed upon a watch glass, concave glass slide or regular flat glass slide. The surface of the glass may have been siliconed or paraffined, if desired. If a flat glass slide is used, it may be kept in a slightly tilted position so as to permit most of the excess blood to collect at the lower end of the marrow fluid pool while a number of the marrow particles remain in a thin film at the upper end of the pool where they can be identified easily. The marrow particles are then picked up with a pipet and transferred to slides or to coverslips from which smears are made and stained. This method requires some speed and dexterity in order to tease out the marrow particles before they become enmeshed in a clot. Because an anticoagulant is not employed in this

modified technic, the resulting marrow smears usually take a somewhat more satisfactory stain than can ordinarily be obtained when heparin, oxalate or citrate has been added to the marrow fluid.

BUFFY COAT SMEARS. — Smears prepared from the buffy coat of centrifuged, heparinized marrow fluid have been advocated by some investigators. In the method described by Limarzi,[17] 1 cc. of marrow fluid is aspirated and immediately placed in a paraffin-lined tube containing a minute amount of heparin. The tube is gently inverted several times. The 1 cc. of heparinized fluid is pipetted into a Wintrobe tube and centrifuged for about five minutes at 2,000 rpm. After centrifuging, the layer of yellow fat, red fat and almost all of the plasma are removed with a pipet. The myeloid-erythroid layer, with some of the adjacent plasma, is then transferred to a paraffin-lined watch glass and mixed. The material is then smeared upon slides which are stained in the usual manner.

PARAFFIN-IMBEDDED CUT SECTIONS. — The method of paraffin-imbedded cut sections of marrow fluid, with certain modifications as described by Lubitz, Greenwalt and Dessel,[18] has been advocated by some investigators. Some of the excess of blood in the aspirate is first taken up by contact with unglazed blotting paper or soft lens paper. By using Zenker's acetic solution instead of formalin, omitting decalcification as unnecessary, and staining the cut sections with Giemsa stain, slides may be obtained with much better preserved cells than with the standard hematoxylin and eosin stain.

Of the four methods described, I recommend the first two for routine use, namely, direct smears of the marrow aspirate and marrow particle smears. In performing marrow aspirations in office practice, it is now our custom first to aspirate about 0.1 cc. with a dry syringe for direct smears and then to aspirate about 1 cc. with a heparin-moistened syringe for marrow particle smears. Only rarely are the direct smears too diluted with blood to be read satisfactorily and, in those cases, the marrow particle smears provide suitable material. It is surprising how frequently, and seemingly rather consistently, direct marrow smears in our hands and in others provide satisfactory slides for diagnosis despite their being necessarily diluted with a considerable proportion of peripheral blood.

Clinical Materials and Methods

The clinical material of this study consisted of 500 successive, unselected patients (table 1) who were referred for hematologic investigation. Of these, 250 patients were from the staff service of the Jackson Memorial Hospital between July 1949 and November 1952 and 250 patients were from private office practice between June 1950 and November 1952. The hospital patients consisted of 127 males and 123 females, of whom 173 were white, 76 were Negroes and 1 was a Seminole Indian. The private patients comprised 114 males and 136 females, of whom 249 were white and 1 was a Negro. The 500 cases in the series were classified as to diagnosis into the following groups, as shown in table 1: anemias 44.2 per cent, hypersplenism 7.8 per cent, leukemia 13.2 per cent, lymphoma 6.4 per cent and other conditions 28.4 per cent. That the age distribution of the hospital and private patients was somewhat similar is shown in figure 4. This barogram also indicates that the greatest number of patients having bone marrow examination were in the 0 to 10 year and in the 30 to 80 year old age groups. Before bone marrow puncture was carried out, each patient was studied by means of a thorough history and physical examination.

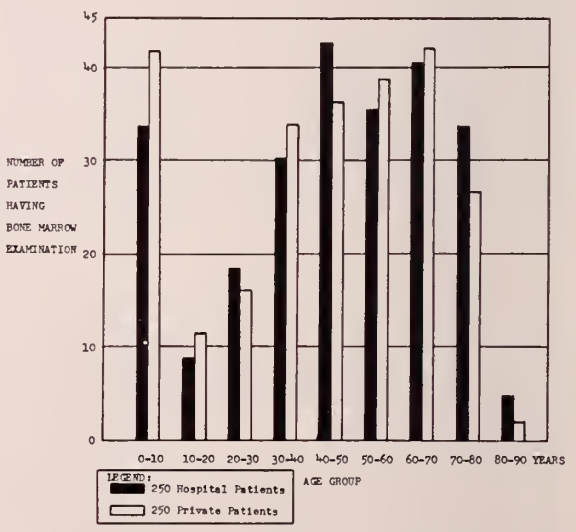


Fig. 4. — Age group distribution of 250 hospital patients and 250 private patients having bone marrow examination.

Table 1. — Diagnosis in 500 Cases in Which Patients (250 Hospital and 250 Private) Had Bone Marrow Examination

	250 Hospital Patients	250 Private Patients	Combined Per Cent (500 Patients)
ANEMIA OR CAUSE OF ANEMIA			
Achrestic		1	0.2
Blood loss	23	6	5.8
Di Guglielmo's	1	1	0.4
Erythroblastosis fetalis	1		0.2
Hemolytic transfusion reaction	1		0.2
Hookworm	2		0.4
Hypochromic, of iron deficiency	6	7	2.6
Hypopituitarism	2	1	0.6
Hypoplastic	17	52	13.8
Hypothyroidism	2		0.4
Idiopathic hypochromic		1	0.2
Infection	15		3.0
Lead poisoning	1		0.2
Liver disease	13	1	2.8
Mediterranean anemia	2	2	0.8
Megaloblastic, of infancy	1		0.2
Megaloblastic, of pregnancy	2		0.4
Nutritional macrocytic	10	5	3.0
Pernicious	14	5	3.8
Rheumatoid arthritis	3	3	1.2
Sickle cell	11		2.2
Uremia	6	3	1.8
Subtotal	133 (53.2%)	88 (35.2%)	44.2
HYPERSPLENISM			
Hemolytic anemia			
Acquired	6	11	3.4
Congenital		1	0.2
Primary splenic neutropenia	1	3	0.8
Thrombocytopenic purpura			
Primary	3	5	1.6
Secondary	4	5	1.8
Subtotal	14 (5.6%)	25 (10.0%)	7.8
LEUKEMIA			
Granulocytic			
Acute	3	8	2.2
Chronic	5	10	3.0
Granulocytic, monocytoid			
Acute	1	1	0.4
Chronic		1	0.2
Lymphocytic			
Acute	6	8	2.8
Chronic	8	9	3.4
Monocytic			
Acute		1	0.2
Chronic	1	3	0.8
Reticulum cell, chronic		1	0.2
Subtotal	24 (9.6%)	42 (16.8%)	13.2
LYMPHOMA			
Follicular lymphoblastoma		1	0.2
Hodgkin's disease	4	2	1.2
Lympholeukosarcoma	3	5	1.6
Lymphosarcoma	2	1	0.6
Melanosarcoma		1	0.2
Multiple myeloma	8	5	2.6
Subtotal	17 (6.8%)	15 (6.0%)	6.4
OTHER CONDITIONS			
Acute infectious lymphocytosis		1	0.2
Agnogenic myeloid metaplasia	3	4	1.4
Agranulocytosis	1	1	0.4
Boeck's sarcoid	1		0.2
Ehlers-Danlos syndrome	1		0.2
Gaucher's disease	2		0.4
Hemophilia	2		0.4
Infectious mononucleosis	4	5	1.8
Leukemoid reaction	5	7	2.4
Lupus erythematosus	3	1	0.8
Neoplasms, metastatic Positive marrow	2	2	0.8
Negative marrow	8	4	2.4
Nonthrombocytopenic purpura		1	0.2
Periarteritis nodosa		1	0.2
Polycythemia Primary	5	11	3.2
Secondary	1	1	0.4
Porphyria, acquired	1		0.2
Pseudohemophilia		5	1.0
Subacute bacterial endocarditis		1	0.2
Weber-Christian disease	1		0.2
No hematologic disorder	22	35	11.4
Subtotal	62 (24.8%)	80 (32.0%)	28.4

The marrow puncture site most frequently used was the sternum, although the iliac crest or a vertebral spine was employed when indicated. In this study marrow smears were prepared directly from about 0.1 cc. to 0.2 cc. of aspirated fluid. Either Wright's stain or a combination of Wright's stain counterstained with Giemsa stain was used. It is my opinion that an accurate and complete description of the marrow slide, including small deviations from normal, can best be made if the examiner or his assistant subjects himself to the discipline of a differential count of the nucleated marrow cells, even if only a relatively small number of cells are counted. In this study a minimum of 200 cells of the marrow were counted in each of the 500 cases. Standard terminology[19] is used in classifying the marrow cells. This classification is shown in table 2, which also lists the normal range of the differential count of adult bone marrow. In every case, peripheral blood smears were obtained for examination at the same time the marrow smears were made. In each of the 500 cases of this study, I personally examined both the marrow smears and peripheral blood smears and dictated the interpretation of the marrow.

Table 2. — Normal Range of the Differential Count of Adult Bone Marrow, as Shown on a Marrow Study Report Sheet

Bone Marrow Study

Cell	%	Normal Range
Myeloblasts		0-5
Progranulocytes		1-8
Myelocytes		
Neutrophil		6-22
Eosinophil		1-2
Basophil		0-1
Metamyelocytes		
Neutrophil		13-32
Eosinophil		0-4
Basophil		0-1
Band Cells		
Neutrophil		15-30
Eosinophil		0-2
Basophil		0-1
Segmented Cells		
Neutrophil		7-30
Eosinophil		1-4
Basophil		0-1
Lymphoblasts		-
Prolymphocytes		-
Lymphocytes		3-20
Description:		

Cell	%	Normal Range
Monoblasts		-
Promonocytes		-
Monocytes		0-5
Plasmablasts		-
Proplasmacytes		-
Plasmacytes		0-2
Megakaryoblasts		-
Promegakaryocytes		-
Megakaryocytes		0-3
Reticulum Cells		0-2
Rubriblasts		-
Prorubricytes		0-4
Rubricytes		2-15
Metarubricytes		7-30
Site of Aspiration		
Cellularity of Marrow Aspirate		
Myeloid-Erythroid Ratio		2.5-4
Cells Counted		

In addition to the examination of the marrow and blood slides, the following minimum studies were carried out in each instance: hemoglobin, red cell count, white cell count, hematocrit reading, platelet count, reticulocyte count and serum bilirubin. The hemoglobin was determined by the photoelectric method. The platelet and reticulocyte counts were performed by the brilliant cresyl blue wet method on the same preparation. When indicated, supravital preparations with peroxidase stain were utilized on marrow and blood samples for identification of granules of monocytes and of granulocytes as opposed to those of cells of the lymphocytic series.

Marrow Picture in Various Diseases

To illustrate generally the value of bone marrow examination, some of the main alterations of marrow cytology are briefly described in some of the more common blood disorders.

The Anemias

Pernicious Anemia and Related Anemias (Fig. 5). — The recognition of an increase of megaloblasts of pernicious anemia type in the bone marrow is of great importance in the diagnosis of pernicious anemia. The presence of megaloblastic cells in a case of anemia, without other explanation for the anemia such as leukemia, is sufficient evidence to indicate a therapeutic trial with liver extract and folic acid even though the peripheral blood studies are inconclusive. In severe cases there may be an almost complete maturation arrest at the megaloblast stage and megaloblasts, rubriblasts and prorubricytes may comprise over 50 per cent of all nucleated cells present. Some of the megaloblasts are extremely primitive cells, and a number of them may be in mitosis. A shift to the left occurs in the white cell series. A characteristic finding is the presence of especially large, hypersegmented polynuclear neutrophils. The cellularity of the marrow is increased.

Achrestic anemia is the term given to an anemia which has the marrow and blood picture of pernicious anemia, but which does not respond satisfactorily to vitamin B_{12} or concentrated liver extract unless adequate doses of folic acid are added.

Other anemias closely related to pernicious anemia are sprue, nutritional macrocytic anemia, tropical anemia, macrocytic anemia of pregnancy and anemia of pellagra. Also included is the anemia due to certain gastrointestinal disturbances (total gastrectomy, intestinal anastomoses). The bone marrow in these anemias is practically

identical with the marrow in pernicious anemia both when in relapse and in remission. The peripheral blood picture, however, may differ from that of pernicious anemia, free acid may be present in the stomach, and lack of proper response to the usual dosage of liver extract is the rule.[20] A few of the patients may respond to large doses of liver extract, but many more of them will obtain a remission from folic acid given in large doses if necessary.

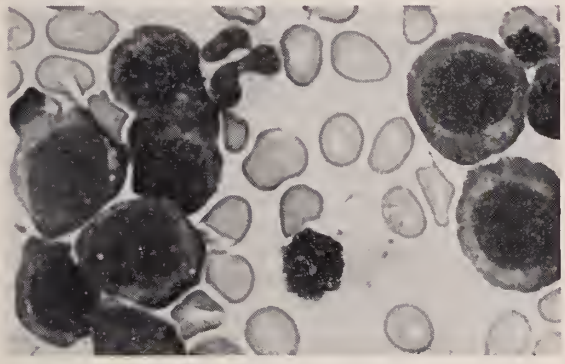


Fig. 5. — Pernicious anemia. (X 725)

Bone marrow studies may also be used as a guide for treatment since liver extract or folic acid effects characteristic changes in the marrow within 24 hours, whereas the peripheral blood may not show evidence of successful therapy for days. After treatment the megaloblasts promptly decrease and finally disappear entirely, large numbers of metarubricytes are formed, the hypersegmented neutrophils disappear, and the white cell series loses its shift toward immaturity.



Fig. 6. — Chronic hypoplastic anemia. (X 575)

Hypoplastic Anemia (Fig. 6). — Bone marrow examination is necessary for the diagnosis of hypoplastic anemia and to rule out aleukemic leukemia and agranulocytosis. If complete aplasia of the marrow is present, a dry tap will be obtained on aspiration, in which case a needle trephine biopsy should be performed to prove the aplasia. This condition is characterized by a profound progressive anemia, little or no splenomegaly, occasionally obstinate bleeding, and usually a fatal outcome. During the course of the disease the bone marrow becomes progressively less cellular and contains more fat than normal, the myeloid elements and nucleated red cells are greatly reduced in number, the megakaryocytes may eventually disappear, and lymphocytes predominate in the smears. During remissions early in the disease, the marrow is occasionally moderately cellular. In osteosclerotic anemia the marrow changes into connective tissue, which later becomes ossified. The peripheral blood picture itself is not specific since it shows only depletion of all blood elements, relative maturity of all cells and no evidence of abnormal blood destruction unless a superimposed hemolytic anemia due to hypersplenism is present. Since aplasia and hypoplasia of the bone marrow may be due to a wide variety of chemical and physical agents, it is important that the diagnosis be made and that the offending agent, if present, be removed.

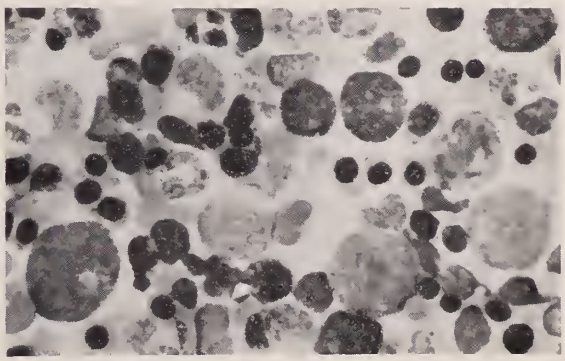


Fig. 7. — Acute hemolytic anemia. (X 375)

Acute Hemolytic Anemia Due to Hypersplenism (Fig. 7). — The chief value of bone marrow examination in this disorder is to rule out aleukemic leukemia, hypoplastic anemia and myeloid metaplasia of the spleen. It has been shown that splenectomy is usually contraindicated if significant marrow depression exists but that favorable results have followed splenectomy

when the bone marrow has been demonstrated to be hyperactive or at least normally active.

This disease is of unknown etiology with sudden onset of profound anemia, toxemia, fever, icterus and splenomegaly in a previously healthy adult. It was first described by Wiseman and Doan[21] under the name of primary splenic neutropenia. In addition to hemolytic anemia, varying degrees of neutropenia and thrombocytopenic purpura may be encountered. Thus, of the three blood elements, namely, red cells, white cells and platelets, any one, any two or all three elements may be depressed in a given case.

The bone marrow typically shows a hyperplasia of the red cell series and, if neutropenia is pronounced, for the white cell series as well. Well over half of the nucleated cells may be red cell precursors, but the similarity to the marrow of pernicious anemia is superficial as the cells are mostly rubricytes, and there is no maturation arrest at the megaloblast or rubriblast stage. In this condition the spleen shows abnormal phagocytosis for red cells and granulocytes and is thought also to exert an inhibitory effect on the bone marrow, thus preventing delivery of mature cells to the circulating blood. Splenectomy usually improves the anemia, at least for a period, and may be, at least temporarily, life-saving in some cases. Splenectomy also usually abolishes the coexisting neutropenia and thrombocytopenia.

Congenital Hemolytic Anemia. — Bone marrow examination should be considered mandatory before undertaking splenectomy for any chronic disorder, and this disease is no exception. Only by this means can one be certain that good functioning marrow tissue will be present after the spleen, a potential site of extramedullary blood formation, is removed. Diagnosis of congenital hemolytic anemia usually offers no difficulty. A history of a chronic anemia occurring in other members of the family, dating from childhood, associated with splenomegaly and punctuated by episodes of jaundice, would be almost pathognomonic. Increased fragility of erythrocytes and spherocytosis are confirmatory. The bone marrow shows considerable hyperplasia of the red cell series at the metarubricyte and rubricyte stage. Granulopoiesis is also increased. Following splenectomy the number of metarubricytes decreases. There is no change in morphology of the red cell precursors to foreshadow the abnormal spherocytic shape of the mature red cells. Dameshek and Bloom[22] made the interesting observation that the bone marrow becomes relatively hypoplastic during and just preceding a hemolytic crisis in this disease.

Other Hemolytic Anemias. — In the group of hemolytic anemias comprising Mediterranean anemia, sickle cell anemia and erythroblastosis fetalis, bone marrow studies are informative but not diagnostic. In all of these disorders the marrow is hyperplastic with a proliferation of metarubricytes and rubricytes, and to a lesser extent of prorubricytes. Granulopoiesis is often increased, with some shift to the left. Phagocytes containing iron pigment and nuclear fragments may be present. In Mediterranean anemia the nucleated red cells may comprise more than half of all nucleated elements in the marrow. In sickle cell anemia the marrow picture is usually much the same whether the spleen has been removed or not.

Iron Deficiency Anemia. — The bone marrow in this condition also shows a hyperplasia of the metarubricytes and rubricytes. The predominant and characteristic cell is a small mature polychromatophilic metarubricyte having an irregular cell outline and a small amount of slate grey cytoplasm about a pyknotic nucleus. Successful therapy with iron or with iron and cobalt returns the bone marrow to normal and abolishes the microcytic hypochromic anemia.

Disturbances of the White Blood Cells

Chronic Granulocytic Leukemia (Fig. 8). — The diagnosis of any of the leukemias in a chronic stage can be definitely established only by bone marrow examination. By means of the marrow smears the aleukemic variety can be diagnosed without difficulty, leukemoid reaction such as from infection can be excluded and agnogenic myeloid metaplasia may also be ruled out. The marrow examination is also useful in estimating the severity of the disease, in anticipating clinical relapse and in affording valuable information for therapeutic control.

The characteristic changes in the bone marrow consist of increased numbers of myeloblasts and myelocytes, a decided increase in cellularity, and the presence of mitotic figures in myelocytes and sometimes in myeloblasts. The ground substance or matrix of the film may contain more granules and debris than are present in normal healthy marrow. When the myeloblasts continue to increase, mitoses are more numerous, and the white cell precursors tend to occur as nests of cells of a single cell type, the process is becoming more acute.

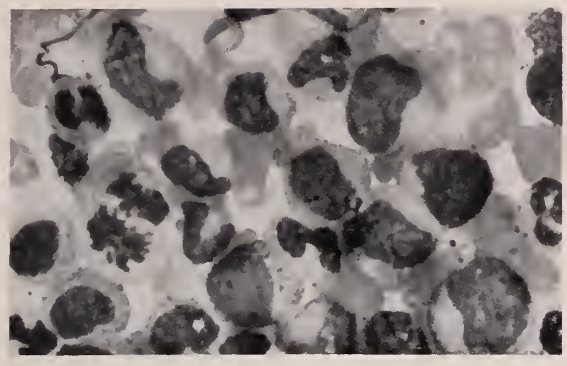


Fig. 8.— Chronic granulocytic leukemia. (X 650)

Chronic Lymphocytic Leukemia (Fig. 9).—Bone marrow examination may be of great value in the diagnosis of chronic lymphocytic leukemia since aleukemic forms are fairly common and in such cases there may not be typical clinical findings. In the aleukemic or leukopenic stage, the marrow picture is just as characteristic as when the lymphocytes are greatly increased in the peripheral blood. In fact, from the marrow examination alone, one cannot say whether or not the circulating blood shows a pronounced leukocytosis or a leukopenia. The outstanding feature of the marrow is the predominance of large numbers of lymphocytes, cells that are never numerous in normal marrow. Most of these cells are of the mature type although occasional lymphoblasts are found. The lymphocytes are closely packed together, but are interrupted in places by islands of nucleated red cells and granulocytic cells. An increase in lymphoblasts foreshadows a clinical relapse to a more acute form of the disease.

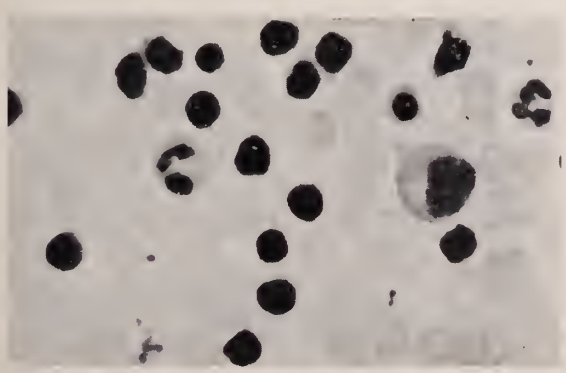


Fig. 9.— Chronic lymphocytic leukemia. (X 650)

Monocytic Leukemia (Fig. 10).—Most cases of monocytic leukemia can be diagnosed from the peripheral blood alone. Aleukemic cases, however, do occur, and unless the bone marrow is studied, the diagnosis may be missed. Pronounced monocytosis from certain infections is occasionally encountered and can be distinguished from monocytic leukemia only by marrow examination.

In this condition, since most cases are acute or subacute, the bone marrow shows so great a proliferation of cells of the monocytic series that normal myeloid tissue may become almost excluded. From 60 to 90 per cent of all the marrow cells may be monocytes, promonocytes or monoblasts. Mitotic cells may be a frequent finding, particularly in the acute stage when they may occasionally be found even in the peripheral blood. Erythropoiesis is ultimately decreased, and a severe myelophthisic anemia develops.

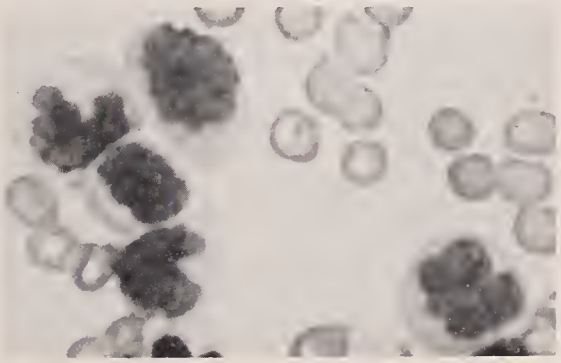


Fig. 10.— Monocytic leukemia. (X 750)

Reticulum Cell Leukemia (Fig. 11).—The reticulum cell is a primitive blood cell from which more differentiated cell types are thought to be derived. It is a large cell, 20 to 30 microns in diameter with abundant dusty blue cytoplasm, the periphery of which is not sharply defined. The nucleus is large, round or oval, is often eccentrically placed, and presents a pale-staining finely reticulated chromatin pattern with one or more nucleoli. This cell is to be distinguished from the reticuloendothelial cell, monoblast, myeloblast and lymphoblast.

In this rare disease, reticulum cell leukemia, the reticulum cells are found in considerable numbers in the marrow and are also found in the peripheral blood, where they may be mistaken for a large lymphocyte by the uninitiated. A panhematocytopenia, with anemia, leukopenia

and thrombocytopenia, usually results. The clinical course is slowly but progressively downhill and may resemble that of a moderately severe chronic hypoplastic anemia.

A related condition, relative hyperplasia of the reticulum cells of the marrow, has been observed in a few patients who have received rather large, repeated doses of roentgen therapy. It is interesting also that reticulum cell hyperplasia of the bone marrow was observed in some of the atom bomb radiation casualties of Hiroshima and Nagasaki.[23]

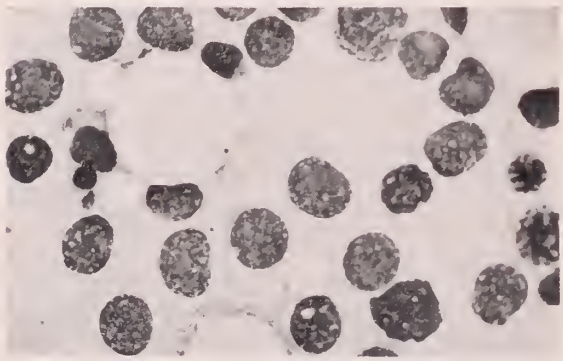


Fig. 11. — Reticulum cell leukemia. (X 475)

ACUTE LEUKEMIA (FIG. 12). — Regardless of whether this condition happens to be an acute exacerbation of chronic leukemia or a primary state, the changes in the bone marrow picture are identical. Furthermore, this picture is unequivocal whether or not leukopenia exists in the peripheral blood. The marrow is infiltrated with large numbers of primitive white blood cell precursors, and there is a great reduction in the number of nucleated red cells and of megakaryocytes. These precursors may be so primitive and undifferentiated that it may not be possible to identify them as myeloblasts, lymphoblasts or monoblasts in a given case. The nuclei of these cells are large, many contain nucleoli, and mitotic figures are numerous.

Serial bone marrow studies have been shown to play a helpful role in the treatment of acute leukemia of children with the folic acid antagonists. In these patients a hematologic relapse in the bone marrow precedes a clinical relapse by a few weeks and indicates the need for further therapy. It is noteworthy that patients treated with the folic acid antagonists may show a bone marrow picture reminiscent of untreated pernicious anemia, as evidenced by increased numbers of megaloblasts and the presence of hypersegmented leukocytes. Before roentgen or other therapy is given to a patient with any type of leukemia, aspirated marrow should be studied for confirmation of the diagnosis, for prognosis and as a guide to therapy.

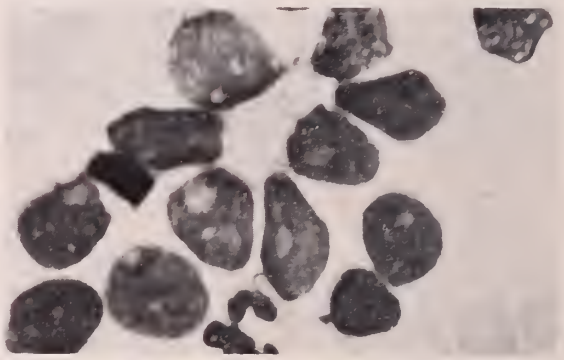


Fig. 12. — Acute granulocytic leukemia. (X 950)

INFECTIOUS MONONUCLEOSIS. — The myelogram in infectious mononucleosis may provide information of diagnostic value since the clinical manifestations of the disease can easily be confused with those of leukemia and since the peripheral blood smear may superficially resemble the picture seen in lymphatic leukemia. In infectious mononucleosis, however, the marrow shows no radical change from normal except for the presence of atypical lymphocytes that have been called "infectious mononucleosis cells."[24] It is to be emphasized that, although these atypical lymphocytes are usually present, they may be absent both from the bone marrow and from the peripheral blood in early stages of this disorder.

LEUKEMOID REACTION. — Leukemoid reaction, often due to infections, may produce such a decided shift to the left of the white cells in the blood as to produce a picture resembling granulocytic leukemia. Undoubtedly cases of supposed leukemia with reported recovery, if diagnosed accurately, might prove to have been examples of leukemoid reaction. The bone marrow is of considerable help in distinguishing this reaction from leukemia, but it must be thoroughly studied. In general, in leukemoid reaction none of the white cells are atypical, myeloblasts usually do not exceed 10 per cent, erythroblasts often increase in proportion to the increase in early forms of white cells, and anemia is usually absent.

Agranulocytosis. — Examination of the bone marrow permits an accurate inventory to be made of damage to the white cell series and enables the possible effectiveness of therapy to be evaluated. The peripheral blood picture and the clinical findings do not necessarily correlate with the actual condition of the marrow.

The marrow findings vary directly with the severity of the toxic process.[25] In mild cases there may be an essentially normal marrow except for some reduction in metamyelocytes and band forms. In moderately severe cases usually a maturation arrest is present at the myeloblast-promyelocyte level, and this picture may be confused by the inexperienced with granulocytic leukemia. In especially severe cases there may be a so-called empty marrow in which granulocytic cells are practically all absent and only lymphocytes, plasma cells and metarubricytes are present in the smears. A hyperplastic marrow showing maturation arrest carries a favorable prognosis, especially with ACTH, or cortisone therapy, whereas an empty or hypoplastic marrow implies a definitely less favorable outlook.

Disturbances of the Platelets

Thrombocytopenic Purpura. — Bone marrow study is most helpful in differentiating primary idiopathic thrombocytopenic purpura from aleukemic leukemia and aplastic anemia with bleeding tendency.

In a typical case of acute, primary thrombocytopenic purpura, the bone marrow shows a conspicuous hyperplasia of megakaryocytes as well as of erythroid and myeloid elements.[26] Many of these megakaryocytes are unusually young forms with nonlobulated single nuclei and a scant deeply basophilic cytoplasm possessing relatively few azurophilic granules and exhibiting decreased development of platelets. In the more chronic case without significant hemorrhage, erythroid and myeloid hyperplasia may be absent, but the hyperplasia of megakaryocytes persists, and these cells tend to be more adult in type with more azurophilic granules. Some of these cells may show an abnormally hyaline cytoplasm. Degenerated or toxic forms of megakaryocytes with vacuoles in the cytoplasm are occasionally seen in primary purpura, but are more often found in some cases of secondary purpura, especially those due to infections and intoxications. With spontaneous recovery the bone marrow shows a drop in the number of megakaryocytes to normal levels and restoration of platelet formation. Following splenectomy, the megakaryocytes usually become normal morphologically, but remain present in moderately increased numbers.

Miscellaneous Disorders Associated With Splenomegaly

Agnogenic Myeloid Metaplasia. — Under the name of agnogenic myeloid metaplasia of the spleen, this condition was first described by Jackson, Parker and Lemon[27] in 1940. It is characterized by splenomegaly of considerable degree, usually no lymphadenopathy, a moderate anemia, a leukemoid blood picture with myeloblasts and megakaryocytes in the circulating blood, and a hypoplastic, fibrotic or sclerotic bone marrow. The spleen largely takes over bone marrow function and usually manufactures red cells, white cells and platelets. The clinical picture resembles that of chronic granulocytic leukemia, and the peripheral blood picture also shows similarities to that leukemia. The diagnosis cannot be made without demonstrating that the bone marrow has not undergone the changes of granulocytic leukemia, but is in fact partly replaced by fibrous tissue.

Lupus Erythematosus. — The bone marrow pattern is not diagnostic in lupus erythematosus. It usually shows a relative increase in plasma cells, however, and this finding alone should lead one to consider the group of diseases associated with hyperglobulinemia, of which lupus is one example.

Fortunately a rather specific test, the test for L. E. cells, is available as an important aid in the diagnosis of this disease in the acute stage. A number of modifications of the original technic have been described.[28, 29] In one of the simplest technics 5 cc. of blood is collected from the patient and also from a normal donor, and these samples are placed in each of two bottles containing sodium and potassium oxalate, in the same manner as if one were going to perform a sedimentation rate. The blood samples are then transferred to Wintrobe hematocrit tubes and centrifuged at 2,000 rpm for five minutes. Equal portions of the plasma from the patient to be tested and of the buffy layer from the normal donor are mixed by gentle shaking in a serologic test tube and are incubated at 37 C. for 20 minutes. Smears are then promptly made from this mixture and they are immediately air-dried and stained with Wright's stain. Control specimens can be prepared by using normal plasma and also a known active L. E. plasma that has been kept

in the deep freeze. Somewhat better preparations may be obtained if fresh heparinized or oxalated bone marrow from a donor is substituted for the donor blood in this method.

The individual L. E. cell of Hargraves is a mature neutrophilic leukocyte which contains one or more masses of nuclear material within its cell membrane. When the L. E. phenomenon by the technic described is rather strongly positive, or when donor bone marrow is substituted for donor blood in the method, a so-called L. E. rosette may sometimes be formed (fig. 13). This rosette is simply a collection of a number of mature neutrophils about the central mass of bluish or reddish-brown, usually homogeneous but sometimes granular material. This mass has been found to represent depolymerized desoxyribose nucleic acid. The factor responsible for its production is a part of the gamma globulin of the patient's plasma.

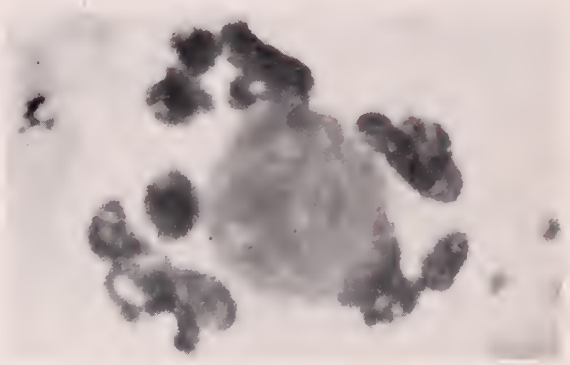


Fig. 13.— L. E. rosette. (X 1150)

The reaction to the L. E. cell test is regularly positive in the acute form of lupus, may be positive or negative in the subacute form and is negative in the localized chronic form of the disease. In relatively few cases have false positives been reported, and these include a case of acute rheumatic fever, a case of multiple myeloma, and several cases of acute serum sickness and of acute allergic reaction to penicillin. The test is therefore considered rather sensitive and quite specific, and represents an important and unique step forward in the diagnosis of acute lupus.

GAUCHER'S DISEASE (FIG. 14).—The diagnosis of this disease is made by demonstrating so-called "foam" cells or Gaucher cells in the bone marrow, where they are usually numerous. These cells are large, 20 to 80 microns in diameter, are round or oval and usually possess one or many small, eccentrically placed nuclei. A characteristic feature is the abundant, pale-staining cytoplasm containing numerous wavy fibrils suggesting a spider's web.[30]

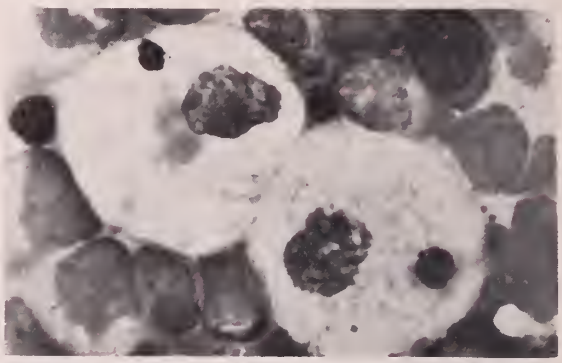


Fig. 14.— Gaucher's cells in bone marrow. (X 800)

POLYCYTHEMIA VERA.—Bone marrow changes are not pathognomonic in polycythemia vera, but may be helpful in confirming the diagnosis in some cases. The marrow usually shows some general increase in cellularity with an increased number of red cell precursors. An increase in megakaryocytes is commonly observed.[31] Polycythemia vera may, however, exist with surprisingly normal bone marrow morphology despite typical changes in the peripheral blood.

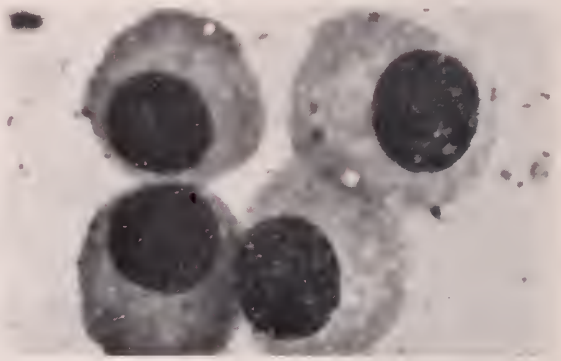


Fig. 15.— Multiple myeloma cells in bone marrow. (X 1000)

Bone Marrow Neoplasms

MULTIPLE MYELOMA (FIG. 15).— Bone marrow aspiration should be performed on all patients in whom the diagnosis of multiple myeloma is suspected. By this means the diagnosis may be definitely established and made earlier than is possible by roentgen findings. Plasma cells in multiple myeloma usually comprise at least 10 per cent of all cells, but may reach over 50 per cent.[32] The so-called multiple myeloma cell dif-

fers from a typical plasma cell in showing less heaping up of the nuclear chromatin, often one or two nucleoli, a more basophilic cytoplasm and less tendency to a perinuclear clear zone. Occasionally it occurs as an especially large cell with two or three nuclei.

Since multiple myeloma cells may sometimes occur in nests and involve the marrow in a patchy distribution, careful microscopic examination of the marrow smears should be carried out and a second aspiration from a different site performed if indicated.

Metastatic Neoplasms (Fig. 16). — In occasional cases an experienced observer can detect malignant cells in marrow aspirated from patients with metastases from primary sites, such as from the prostate, breast, kidney, stomach and thyroid. They appear as large, bizarre cells, usually in clumps, with little cytoplasm, and a hyperchromatic nucleus containing one to three nucleoli. Plasma cells are sometimes considerably increased in number, but this is not a constant finding. The chance of demonstrating metastatic tumor cells is increased if use is made of one of the methods of concentrating marrow (vide supra), such as the method of marrow particle smears.

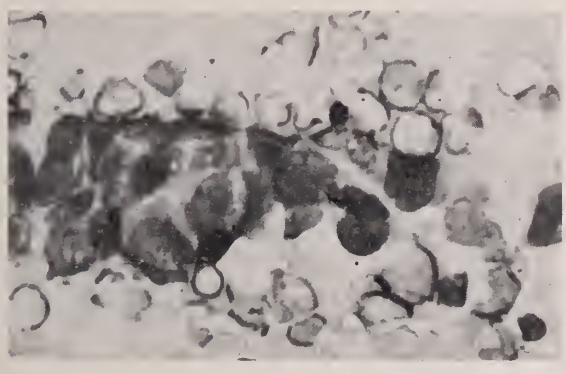


Fig. 16. — Metastatic carcinoma in bone marrow. (X 350)

Clinical Value of Marrow Examination of Five Hundred Patients

A summary of the clinical value of bone marrow examination of 500 patients is shown in table 3. The marrow examination was of diagnostic value in as many as 40.6 per cent of the patients, was of confirmatory value in 7.8 per cent, and was of clinical value for exclusion of a blood disorder in 31.4 per cent. Marrow cytology was deemed of no clinical value but as being actually or theoretically useful in teaching in 6.4 per cent, while it was judged to be of no value in 13.8 per cent. In 85 out of 250 hospital patients, and in as many as 118 out of 250 private patients, marrow examination was of diagnostic value. As would be expected, the marrow examination was requested somewhat more freely by resident physicians of the hospital than in the more discriminating referrals of private physicians. Attesting, however, to the relative appropriateness of marrow aspiration in both groups is the fact that marrow examination was found to be of some clinical value in 75.6 per cent of 250 hospital staff patients and in 84.0 per cent of 250 private patients.

Table 3. — Clinical Value of Bone Marrow Examinations

	250 Hospital Patients	250 Private Patients	Combined Per Cent (500 Patients)
Clinical Value			
Diagnostic value	85	118	40.6
Confirmatory value	14	25	7.8
For exclusion of a blood disorder	90	67	31.4
Subtotal	189 (75.6%)	210 (84.0%)	79.8
No Clinical Value			
Useful in teaching	27	5	6.4
No value	34	35	13.8
Subtotal	61 (24.4%)	40 (16.0%)	20.2

Disorders in which marrow examination is of diagnostic value are: acute and chronic leukemia, hypoplastic anemia, agranulocytosis, megaloblastic anemias, such as pernicious anemia and related anemias, multiple myeloma, agnogenic myeloid metaplasia, carcinoma metastases to bone and lipoid histiocytoses such as Gaucher's disease.

Disorders in which marrow examination is of confirmatory value are: congenital and acquired hemolytic anemias, idiopathic and acquired thrombocytopenic purpuras and primary splenic neutropenia.

Examples of groups of disorders in which marrow examination may be of clinical value for exclusion of a blood disorder are: leukopenias, leukemoid reactions, bleeding disorders, polycythemias, and anemias from various causes including iron deficiency, uremia, hepatic insufficiency and certain endocrinopathies.

Conclusions

In general, marrow examination should be performed: (1) to diagnose obscure conditions presenting anemia, leukopenia or thrombocytopenia; (2) as an aid in ruling out disorders mimicking blood dyscrasias, as when the patient exhibits enlarged lymph nodes and an enlarged spleen; (3) when a definite diagnosis cannot be made by any other means, such as in aleukemic leukemia; (4) whenever the peripheral blood picture is inconclusive as to etiology, as in hypoplastic anemia; (5) as a confirmatory diagnostic procedure as in the diseases of hypersplenism; (6) as a mandatory examination before splenectomy for any hematologic disorder to rule out aplasia of the marrow; (7) to facilitate treatment of certain hematologic diseases, for example, in treating acute leukemia of children with folic acid antagonists; (8) as a possible means of proving carcinoma metastases to bone; and (9) to demonstrate the characteristic histiocytes in some of the diseases of lipid metabolism.

The study of the bone marrow constitutes not only a practical and valuable diagnostic tool in diseases of the blood, but in many instances it has become an integral part of a complete investigation of the patient presenting a diagnostic problem. Although many diseases do not show a specific marrow cytology, nevertheless, study of the marrow may yield information valuable to the differential diagnosis and management of the patient. It should not be assumed, however, that the bone marrow is always diagnostic in a given condition and that marrow examination can be substituted for thorough clinical investigation of the patient.

The proper interpretation of marrow cytology requires considerable training and experience as well as time and patience. While one easily can establish the diagnosis of leukemia from the recesses of the laboratory without ever seeing the patient, there is a host of other conditions in which one can give a much more enlightened and helpful marrow interpretation after full consideration of the detailed clinical findings and preferably after having the advantage of standing at the patient's bedside.

Summary

Some of the historical highlights of bone marrow aspiration are reviewed.

The technics of sternal, iliac crest and vertebral marrow puncture are described. The sternum is well adapted for routine use, but the iliac crest or a vertebral spine is preferred in certain situations.

Bone marrow aspiration is a simple bedside procedure and is unsurpassed for cytologic study of the marrow. It is usable at all age periods and is contraindicated only in hemophilia.

Some of the important technics for preparation of marrow slides are described. I use the method of direct smears of the aspirate and supplement this with the method of marrow particle smears when indicated.

The characteristic bone marrow picture and its diagnostic significance are described in some of the more common blood disorders.

The clinical value of marrow examination of 500 patients is reported. Marrow examination was of diagnostic value in 40.6 per cent of these patients, was of confirmatory value in 7.8 per cent and was of clinical value for exclusion of a blood disorder in 31.4 per cent. Marrow study was deemed of no clinical value but as useful in teaching in 6.4 per cent and was judged to be of no value in 13.8 per cent.

The marrow examination has an important place in clinical medicine because it is the only method of establishing a definite diagnosis in certain blood disorders, confirms the diagnosis in certain cases and informs the physician as to the presence or absence of certain diseases which he must consider in the differential diagnosis in some patients.

Full reliance should be placed upon bone marrow interpretation only when it is reported by an experienced observer who has made a careful correlation with the clinical findings and, when indicated, with other laboratory data.

Grateful acknowledgement is made to Mrs. Maxine Ace, Chief Technician, Hematology Laboratory, Jackson Memorial Hospital, for the valuable technical assistance which she gave without stint in the preparation and differential counting of marrow smears of the hospital patients in this study.

The photographs and microphotographs were made by Mr. William Atkinson, Chief Photographer, Photographic Laboratory, Jackson Memorial Hospital.

References

1. Mendell, T. H.; Meranze, D. R., and Meranze, T.: Clinical Value of Sternal Bone Marrow Puncture, Ann. Int. Med. 16:1180-1196 (June) 1942.
2. Vogel, P.; Erf, L. A., and Rosenthal, N.: Hematological Observations on Bone Marrow Obtained by Sternal Puncture. Am. J. Clin. Path. 7:436-447 (Sept.) 1937, 498-515 (Nov.) 1937.
3. Peabody, F. W.: Pathology of Bone Marrow in Pernicious Anemia, Am. J. Path. 3:179-202 (May) 1927.
4. Dameshek, W.: Biopsy of Sternal Bone Marrow; Its Value in Study of Diseases of Blood-Forming Organs, Am. J. M. Sc. 190:617-640 (Nov.) 1935.
5. Rubinstein, M. A.: Technic and Diagnostic Value of Aspiration of Bone Marrow from Iliac Crest, Ann. Int. Med. 32:1095-1098 (June) 1950.
6. Dameshek, W.: Marrow Biopsy Techniques, Lab. Digest 12:3-4 (Jan.) 1949.
7. Loge, J. P.: Spinous Process Puncture; Simple Clinical Approach for Obtaining Bone Marrow, Blood 3:198-204 (Feb.) 1948.
8. Hynes, M.: Sternal Puncture, Lancet 1:1373-1379 (June 17) 1939.
9. Rheingold, J. J.; Weisfuse, L., and Dameshek, W.: Multiple Sites for Bone-Marrow Puncture with Particular Reference to Children, New England J. Med. 240:54-56 (Jan. 13) 1948.

10. Fortner, J. G., and Moss, E. S.: Death Following Sternal Puncture: Report of 2 Cases, Ann. Int. Med. 34:809-815 (March) 1951.
11. Meyer, L. M., and Halpern, J.: Deaths Following Sternal Puncture, Am. J. Clin. Path. 14:247-248 (April) 1944.
12. Rosenthal, N.: Value of Bone Puncture for Obtaining Marrow as Diagnostic Procedure, Bull. New York Acad. Med. 26:555-564 (Aug.) 1950.
13. Fadem, R. S., and Berlin, I.: Comparisons Between Bone Marrow Differentials Prepared from Particles and from Random Samples of Aspirate and Determinations of Dilution of Aspirate with Peripheral Blood Utilizing Radioactive Phosphorus (P^{32}), Blood 6:160-174 (Feb.) 1951.
14. Berlin, N. I.; Hennessy, T. G., and Gartland, J.: Sternal Marrow Puncture: Dilution with Peripheral Blood as Determined by P^{32} Labeled Red Blood Cells, J. Lab. & Clin. Med. 36:23-28 (July) 1950.
15. Segerdahl, E.: Uber Sternalpunktion, Acta. med. Scandinav., suppl. 64:1-162, 1935.
16. Propp, S.: Improved Technic of Bone Marrow Aspiration, Blood 6: 585-599 (July) 1951.
17. Limarzi, L. R.: Evaluation of Bone Marrow Concentration Techniques; Modified Method for Simultaneous Preparation and Staining of Blood and Bone Marrow Films, J. Lab. & Clin. Med. 32:732-740 (June) 1947.
18. Lubitz, J. M.; Greenwalt, T. J., and Dessel, B.: Preparation of Aspirated Marrow for Sectioning, Am. J. Clin. Path. 22:291-293 (March) 1952.
19. Recommended Terms and Definitions for Cells of the Leukocytic, Erythrocytic and Thrombocytic Series, J. A. M. A. 139:175-176 (Jan. 15) 1949.
20. Davidson, L. S. P.: Refractory Megaloblastic Anemia, Blood 3:107-120 (Jan.) 1948.
21. Wiseman, B. K., and Doan, C. A.: Primary Splenic Neutropenia; Newly Recognized Syndrome, Closely Related to Congenital Hemolytic Icterus and Essential Thrombocytopenic Purpura, Ann. Int. Med. 16:1097-1117 (June) 1942.
22. Dameshek, W., and Bloom, M. L.: Events in the Hemolytic Crisis of Hereditary Spherocytosis, with Particular Reference to Reticulocytopenia, Pancytopenia and Abnormal Splenic Mechanism, Blood 3:1381-1410 (Dec.) 1948.
23. Liebow, A. A.; Warren, S., and DeCoursey, E.: Pathology of Atomic Bomb Casualties, Am. J. Path. 25:853-1027 (Sept.) 1949.
24. Freeman, W.: Bone Marrow Studies in Glandular Fever (Infectious Mononucleosis), Am. J. Clin. Path. 6:185-194 (March) 1936.
25. Limarzi, L. R., and Ricewasser, H.: Thiouracil Granulocytopenia and Agranulocytosis; Prognostic Value of Sternal Marrow Examination, Am. J. Clin. Path. 16:306-318 (May) 1946.
26. Limarzi, L. R.: Thrombocytopenic Purpura, M. Clin. North America 28:153-186 (Jan.) 1944.
27. Jackson, H. Jr.; Parker, F. Jr., and Lemon, H. M.: Agnogenic Myeloid Metaplasia of the Spleen; Syndrome Simulating Other More Definite Hematologic Disorders, New England J. Med. 222:985-994 (June 13) 1940.
28. Hargraves, M. M.; Richmond, H., and Morton, R.: Presentation of 2 Bone Marrow Elements; "Tart" Cell and "L.E." Cell, Proc. Staff Meet., Mayo Clin. 23:25-28 (Jan. 21) 1948.
29. Berman, L.; Axelrod, A. R.; Goodman, H. L., and McClaughry, R. I.: So-called "Lupus Erythematosus Inclusion Phenomenon" of Bone Marrow and Blood; Morphologic and Serologic Studies, Am. J. Clin. Path. 20:403-418 (May) 1950.
30. Groen, J., and Garrer, A. H.: Adult Gaucher's Disease with Special Reference to Variations in Its Clinical Course and Value of Sternal Puncture as Aid in Its Diagnosis, Blood 3:1221-1237 (Nov.) 1948.
31. Manning, I. H. Jr.: Diagnostic Value of Sternal Bone Marrow Puncture in Polycythemia Vera, Am. J. M. Sc. 214: 469-475 (Nov.) 1947.
32. Bayrd, E. D.: Bone Marrow on Sternal Aspiration in Multiple Myeloma, Blood 3:987-1018 (Sept.) 1948.

618 duPont Building.

ABSTRACTS OF MEDICAL ARTICLES

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 1018, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

The Journal of the American Medical Association is limiting its Current Medical Literature section. Thus, our main source of information on articles written by our members has been greatly curtailed.

Pleuropulmonary Tularemia Complicated by Peripheral Neuritis. By Mortimer Raphael, M.D., and Augustus E. Anderson, M.D. A. M. A. Arch. Int. Med. 91:278-280 (Feb.) 1953.

The case of pleuropulmonary tularemia reported here is unusual in that it was complicated by peripheral neuritis, hitherto unreported as a complication of this disease. Treatment with aureomycin was successfully carried out. It was concluded that tularemia should be added to the long list of infectious diseases which may be complicated by polyneuritis secondary to absorption of bacterial toxins.

Post-Traumatic Subdural Hydroma, Report of a Case of Massive External Hydrocephalus. By Irwin Perlmutter, M.D., and Richard E. Strain, M.D. A. M. A. Arch. Surg. 67:122-125 (July) 1953.

A case of chronic subdural hydroma — external hydrocephalus — following trauma is reported. The massive reaccumulating collection of subdural fluid, which caused ventricular displacement of considerable degree, was successfully treated by the insertion of a polyethylene tube intracranially to drain the subdural hydroma into the right mastoid antrum.



The Sunshine City Welcomes the Florida Medical Association

St. Petersburg, the convention city for the Eighty-First Annual Meeting of the Florida Medical Association, April 3-6, 1955, has peculiar attraction for Floridians, apart from its national and international appeal to visitors. Almost surrounded by salt water, dotted with fresh water lakes, indented by bayous and inlets, it is a gem fringed by a necklace of picturesque keys in the Gulf of Mexico. Here is a city apart, unique in its setting of natural beauty, of which Florida is particularly proud. Long recognized as America's Sunshine City, it lures countless vacationers, transforms an astonishing number of casual visitors into permanent residents, and steadily increases its claim to the title of convention capital of Florida's West Coast.

Climate is the most obvious reason for St. Petersburg's popularity. It boasts an average mean temperature of 72 degrees, with only 14 degrees separating winter and summer temperatures. Proclaimed the sunniest city in America by Harvard University meteorologists after a nationwide survey, it is known far and wide for its "sunshine offer," established in 1910 by the St. Petersburg Evening Independent. This is the only newspaper in the world which gives away its editions on days when the sun fails to shine before press time. This custom has resulted in an average of less than five free issues a year.

Because of the metropolitan character of its resident and visitor population, St. Petersburg has the cultural, shopping, hotel, entertainment and educational advantages of a city many times its size. In its favored location on a peninsula jutting into the Gulf of Mexico, it also offers many recreational facilities. Some 40 parks covering more than 1,000 acres provide relaxation. Altogether, the city has 33 miles of shore line, in addition to 21 miles of incomparable Greater Gulf Beaches, to enhance its intriguing landscapes and afford boundless opportunities for fishing, boating and bathing.

A characteristic St. Petersburg attraction is the Million Dollar Recreation Pier, which extends half a mile into Tampa Bay and provides excellent accommodations for tourist play. On the pierhead the two story casino houses a restaurant, a convention and dance hall, an immense space for picnics, and the studios of WSUN, the city-owned radio and television station.

An attraction of special interest to all convention visitors is the spectacular new Sunshine Skyway, longest crossing of its kind in the world, stretching 15 miles across Tampa Bay from St. Petersburg to its southern terminus on the Florida mainland just north of Bradenton. Opened to traffic last Labor Day, the Skyway rises to a maximum of 150 feet above the water and provides a magnificent view of the St. Petersburg area. A trip across the bridge is a memorable experience no visitor will want to miss.

The Sunshine City is nationally known as the winter capital of baseball. The New York Yankees and the St. Louis Cardinals train there, and during the spring training season they play daily exhibition games with most of the other major league clubs at Al Lang Field, the finest small stadium in America. Other sports events include the St. Petersburg-Havana Yacht Race, the West Coast Tennis Tournament, and the St. Petersburg Open Golf Tournament. The famous Festival of States concludes each winter season, the dates this year being March 28 through April 2, with the parade on April 1.

Extending a mile along the waterfront in downtown St. Petersburg, tropical parks present a panorama of beauty, with their profuse vegetation, fountains and Greek and Roman statuary. Fronting on the Bay are magnificent seasonal hotels and the luxurious St. Petersburg Yacht Club.

Outstanding among these hotels is the Vinoy Park Hotel (opposite page, center right), the headquarters for the 1955 Annual Meeting. Eighteen years have elapsed since the Association last met at the Vinoy Park in 1937, but its 1944 meeting was held elsewhere in St. Petersburg. This hotel, spanning a full city block, overlooks a private yacht basin and beautiful Tampa Bay. Comparable accommodations are available at the Soreno Hotel (opposite page, lower right), located just across Waterfront Park four blocks from the Vinoy Park. Transportation will be provided between

(Continued on page 775)



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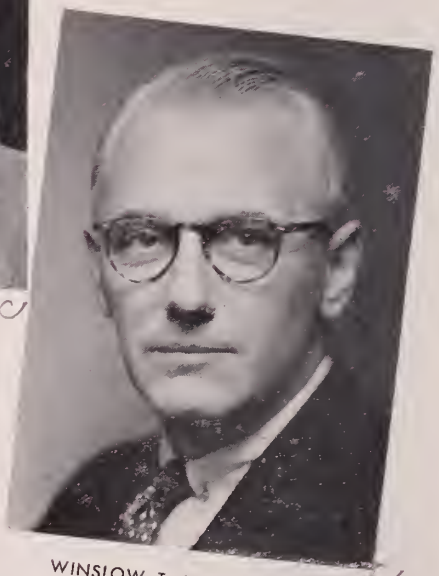
ELMER HESS, M.D.
President-Elect
American Medical Association
Erie, Pa.



JEROME S. HARRIS, M.D.
Chairman of Pediatric Dept. of the Duke University School of Medicine and Duke Hospital
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ALTON OCHSNER, M.D.
William Henderson Professor of Surgery
Chairman, Dept. of Surgery, Tulane University of Louisiana School of Medicine
New Orleans



WINSLOW T. TOMPKINS, M.D.
Associate Professor of Obstetrics and Gynecology
University of Pennsylvania
Philadelphia



Claude J. Hunt, M.D., Guest Speaker

Dr. Claude J. Hunt, the son of James B. and Martha Ellen (Totty) Hunt, was born in Warren County, Kentucky. After receiving the Bachelor of Arts degree from Bethel College in his native state, he attended the University of Kansas School of Medicine, where he was awarded the degree of Doctor of Medicine. Upon completion of an internship in the Kansas City General Hospital and one year of house surgical service at Wesley Hospital in Kansas City, Mo., he served as surgical assistant for five years with a prominent Kansas City surgeon, the late Dr. W. J. Frick. At various times he pursued postgraduate medical studies at the Washington University School of Medicine in St. Louis, the Harvard Medical School in Boston, the University of Montpelier in France and the University of Vienna in Austria.

This distinguished Kentuckian and eminent surgeon in the state of his adoption is Chief of Surgery at Research Hospital in Kansas City, Surgeon at Research Clinic, Kansas City General Hospital, Menorah Hospital and St. Mary's Hospital, and Chief of the Hunt Surgical Group. He is a past president of the Jackson County (Mo.) Medical Society and of the American Goiter Association, and is a former chairman of the Surgical Section of the Southern Medical Association. The numerous medical societies in which he holds membership include the Western Surgical Association, Central Surgical Association, International Surgical Society, Pan-Pacific Surgical Association, American College of Surgeons, Southwestern Surgical Congress and International College of Surgeons. He is an honorary member of the St. Paul Surgical Society, the Philadelphia Proctological Society and the Rocky Mountain Radiological Society. He is certified by the American Board of Surgery. An author of note, he has published numerous surgical articles.

Dr. Hunt is married to the former Miss Katherine Louise Huttig.

PROGRAM

of the

Eighty-First Annual Meeting

FLORIDA MEDICAL ASSOCIATION

to be Held at ST. PETERSBURG

APRIL 4, 5 and 6, 1955

REGISTRATION

Entrance to Palm Room, Vinoy Park Hotel

The Registration Desk will be located in the lobby of the Vinoy Park Hotel at the entrance to the Palm Room and will be open Sunday, Monday and Tuesday, 8:30 a.m. to 5:30 p.m., and Wednesday, 8:30 a.m. to 12:30 p.m. Every member will be required to register and obtain an identification badge before attending any of the sessions. Guests and ladies are required to register at the above designated Registration Desk and obtain their badges.

There is no fee for registration. Printed programs may be obtained at the Registration Desk.

CONVENTION HEADQUARTERS

VINOY PARK HOTEL

The general headquarters will be the Vinoy Park Hotel, where the registration desk, assembly room for general sessions, meeting place of the House of Delegates, scientific assemblies, information desk and technical exhibits will be located. The scientific exhibits will be located in the Soreno Hotel.

The specialty groups approved by the Board of Governors will meet Saturday through Tuesday, at the Vinoy Park Hotel, the Soreno Hotel and the Yacht Club.

GOLF

Great things are in store for golfing doctors of Florida at the coming State Medical Meeting in St. Petersburg, starting Sunday, April 3. Two of St. Petersburg's fine golf courses are to be made available at a special greens fee of $2.00. One is the Sunset Golf and Country Club on Snell Isle where Joe Guisick and Toby Lyons are the professionals. Sunset is a very beautiful course in excellent condition, somewhat shorter than the second course available, the championship course of Lakewood Country Club where the famous St. Petersburg Open is held. This will also be available at the same $2.00 greens fee. Professionals here are Skip Alexander, Eddie Thompson and Al Rosseter.

The golfing committee has tentatively decided that all golfers who wish to compete for the low gross prizes must use the Lakewood course since it offers a greater test of golfing ability. The net score prizes may be competed for on either of the courses.

The tournament will run through Tuesday, April 5. An entrance fee of $1.00 shall be paid to the starter and the score card must be dated, signed, attested and turned in to the starter at the end of the round. The local professionals will calculate the net score using the Calloway system. There will be prizes for low net and low gross as well as numerous other prizes. Plan now to compete in this fine tournament.

The Orlando cup is awarded annually to the low net scorer. Last year's winner was Dr. James T. Shelden of Lakeland. Dr. Shelden also won the Keleket X-Ray trophy for the third year in a row which retired it. This trophy is limited to the radiology division of the tournament. The Duval County Medical Society trophy is awarded to the low gross scorer. Last year's winner was Dr. David W. Martin of West Palm Beach.

Members of the Auxiliary will stage their annual tournament at the same courses and under the same conditions as the men. They have their own separate list of prizes including an annual trophy presented this year for the first time by the Orange County Medical Society to the holder of the low gross score.

Those desiring further information are asked to communicate with Dr. Harry L. Allan Jr., Chairman, Golf Committee, 432 Third St., N., St. Petersburg.

ANGLERS

Enjoy a deep sea fishing trip while at the Convention. Parties arranged for half day or all day trips.

For reservations and information please communicate with Dr. Edward V. Pollard, 700 6th Ave., S., St. Petersburg.

TRANSPORTATION

City busses which will seat forty passengers have been obtained from the City of St. Petersburg for transportation from the hotels and other activities in the city. These busses will shuttle between the hotels, Soreno and Vinoy Park, at regular intervals for the duration of the convention between the hours of 8:30 a.m. and 1:00 a.m., and also will be available for use of special parties.

PATIO PARTY

Tuesday, 6:00 p.m.

VINOY PARK HOTEL — POOL PATIO

The annual Smoker has been discontinued this year and in its place will be held the Patio Party. This fellowship and cocktail hour will immediately precede the Annual Dinner and will be held on the Vinoy Park Hotel grounds in the pool area.

Tags for the Patio Party will be on sale at the registration desk ($2.50 per person). Informal entertainment appropriate to the occasion is being arranged by the local committee.

ASSOCIATION DINNER

Tuesday, 7:00 p.m.

Vinoy Park Hotel — Main Dining Room

Those who are not lodging at the Vinoy Park or the Soreno Hotels may obtain dinner tickets ($5.75 per person) from the hotel cashier.

HOTELS

Vinoy Park — Hotel Headquarters

(American Plan)

Double occupancy of twin-bedded rooms:	$13 per person
Single occupancy of twin-bedded rooms:	$20
Single occupancy of Single-bedded rooms:	$16
Parlors:	$15

Soreno Hotel

(American Plan)

Double occupancy of twin-bedded rooms:	$12 per person
Single occupancy of twin-bedded rooms:	$18
Single occupancy of single-bedded rooms:	$14
Parlors:	$12

American Plan rates at the Vinoy Park Hotel include meals, which are priced as follows:

Breakfast	$1.75
Luncheon	3.00
Dinner	4.75
Banquet	5.75

Persons not lodging at the headquarters hotel may be served meals in the Main Dining Room at the prices quoted. Individual meal tickets sold at cashier's window will include gratuities and state tax on meals for those who do not have rooms in the Headquarters Hotel.

For your convenience we have arranged with the hotel management that there shall be no tipping at any meal. A charge of $1.25 per day will be posted to your hotel account to provide gratuities for dining room employees.

OTHER AVAILABLE ACCOMMODATIONS

HOTELS

Albemarle

(145 3rd Ave. N.E.)

Single Rooms	$ 5.00- 6.00
Double Rooms	$ 7.00- 8.00

Carleve

(4th Ave. & 2nd St. N.)

Single Rooms	$ 8.00
Double Rooms	$ 8.00

(Same rate prevails if occupied by 1 or 2 guests.)

Carr

(161 2nd Ave. N.)

Single Rooms	$ 5.00
Double Rooms	$ 8.00

Colonial

(126 2nd Ave. N.E.)

Single Rooms	$ 3.00- 5.00
Double Rooms	$ 5.00- 7.00

Concord

(2nd Ave. N. & 1st St.)

Single Rooms	$ 5.00- 6.00
Double Rooms	$ 8.00- 9.00

Huntington

(4th Ave. & 2nd St. N.)

Single Rooms	$12.00
Double Rooms	$16.00

Mount Vernon

(219 4th Ave. N.)

Single Rooms	$ 5.00
Double Rooms	$ 8.00

Pheil

(Central Ave. at 4th St.)

Single Rooms	$ 6.00
Double Rooms	$10.00

Princess Martha

(1st Ave. & 4th St. N.)

Single Rooms	$ 6.00- 7.00
Double Rooms	$ 8.00- 9.00

Sevilla

(233 2nd St. N.)

Single Rooms	$ 4.00- 6.00
Double Rooms	$ 7.00- 9.00

Suwannee

(501 1st Ave. N.)

Single Rooms	$ 8.00-10.00
Double Rooms	$13.00-16.00

Tides

(Gulf Blvd., Redington Beach)

Single Rooms	$14.00
Double Rooms	$16.00

MOTELS

Bay State

(4050 4th St. N.)

Single Rooms	$ 5.00
Double Rooms	$ 5.00

(Same rate prevails if occupied by 1 or 2 guests)

Cavalier

(1325 4th St. N.)

Single Rooms	$ 7.00
Double Rooms	$ 8.00

Cocoanut Grove

(2922 4th St. N.)

Single Rooms	$ 6.00
Double Rooms	$ 8.00-14.00

Lewis Palm Park

(4100 4th St. N.)

Single Rooms	$ 4.00
Double Rooms	$ 5.00- 6.00

Monticello Motor Inn

(1700 4th St. N.)

Single Rooms	$ 8.00
Double Rooms	$ 8.00

(Same rate prevails if occupied by 1 or 2 guests.)

BEACH APARTMENTS

Gulf Winds Hotel

(6805 Gulf Blvd., Gulf Beaches)

Villas (2 people)	$10.00
Villas (3 people)	$12.00
Efficiency Apartments (2 people)	$10.00
1 Bedroom Apartments (2 people)	$12.00
1 Bedroom Apartments (3 people)	$15.00
2 Bedroom Apartments (4 people)	$16.00
2 Bedroom Apartments (5 people)	$18.00

La Playa

(16326 Gulf Blvd., Gulf Beaches)

Efficiency Apartments	$10.00
1 Bedroom Apartments	$12.00
2 Bedroom Apartments	$16.00

TECHNICAL EXHIBITS

Technical exhibits will be located on the veranda, in the lobby, in the Palm Room and on the mezzanine of the Vinoy Park Hotel. The technical exhibits have a real scientific value, and the physicians who wish to keep abreast of the times and be familiar with the latest development in drugs and medical appliances should spend some time with these exhibits; a surprising amount of useful information can be procured in this way. Many exhibitors make no attempt to sell, the representatives of the firms being there primarily to give the latest information regarding their products. Those who have items for sale will gladly give information whether there is a purchase or not. Be sure to register your name with the various representatives who are exhibiting.

The following firms have arranged for exhibits at the St. Petersburg meeting:

Booth	Exhibitor
1.	G. D. Searle & Co.
2.	Smith, Kline & French Laboratories
3.	The Nestlé Company
4.	VanPelt & Brown, Incorporated
5.	Eli Lilly and Company
6.	Holland-Rantos Company, Inc.
7.	Winthrop-Stearns Inc.
8.	Surgical Supply Company
9.	Schering Corporation
10.	A. H. Robins Company, Inc.
11.	The Medical Protective Company
12.	Hoffmann-LaRoche Inc.
13.	Pet Milk Company
14.	C. B. Fleet Co., Inc.
15.	Ayerst Laboratories
16.	Bilhuber-Knoll Corporation
17.	Keleket X-Ray of Florida
18.	J. B. Roerig and Company
19.	Eaton Laboratories, Inc.
20.	Parke, Davis & Company
21.	The S. E. Massengill Company
22.	Pfizer Laboratories
23.	McCall-Rising, Inc.
24.	Abbott Laboratories
25.	Florida Brace Corporation
26.	Ames Company, Inc.
27.	Standard X-Ray Company
28.	Continental X-Ray Corporation
29.	Guild of Prescription Opticians of Florida
30.	Gerber Products Company
31.	J. A. Majors Company
32.	White Laboratories, Inc.
33.-34.	A. S. Aloe Company
35.-36.	The Coca-Cola Company
37.	Sharp & Dohme, Inc.
38.	Tablerock Laboratories
39.	General Electric Company, X-Ray Dept.
40.-41.	Surgical Equipment Company
42.	Parco Surgical Supplies
43.	Brayten Pharmaceutical Company
44.	The Wm. S. Merrell Company
45.	Maltbie Laboratories Div., Wallace & Tiernan Inc.
46.-47.	Rowland Laboratories
48.	Mead Johnson & Company
49.	Anderson Surgical Supply Co.
50.	Ciba Pharmaceutical Products, Inc.
51.	The Borden Company
52.	Medical Supply Company
53.	Carnation Company
54.	Ortho Pharmaceutical Corporation
55.	Ives-Cameron Company
56.	Riker Laboratories, Inc.
57.	Walker Laboratories, Inc.
58.	Picker X-Ray Corporation
59.	E. R. Squibb & Sons
60.	Paust Manufacturing Co.
61.	Sandoz Pharmaceuticals
62.	Executone, Inc.
63.	Eisele & Company
64.	The Upjohn Company
65.	R. J. Reynolds Tobacco Company
66.	Burroughs Wellcome & Co. (U.S.A.) Inc.
67.	Sherman Laboratories
68.	Encyclopedia Americana
69.	Carroll Dunham Smith Pharmacal Company
70.	Blair's Associate
71.	S. J. Tutag & Company
72.	Audio-Digest Foundation
73.-74.	Ritter Company, Inc.
75.	M & R Laboratories
76.	Kellogg Company
77.	Arlington-Funk Labs. Div., U. S. Vitamin Corp.
78.	Lederle Laboratories Div., American Cyanamid Co.

SCIENTIFIC EXHIBITS

The scientific exhibits will be located on the mezzanine of the Soreno Hotel. We consider ourselves fortunate to be able to present for your approval the following exhibits:

1.	Hemangioma Therapy, Wesley W. Wilson, M.D., Tampa.
2.	The Surgical Management of Aortic Aneurysms, Francis N. Cooke, M.D., Miami.
3.-4.	A New Method for Treating Peripheral Vascular Diseases, James F. Lyons, M.D., Coral Gables.
5.	Nerve Block Therapy, Harold Carron, M.D., Tampa.
6.	Bureau of Narcotics, Florida State Board of Health, Mr. Frank S. Castor, Director, Jacksonville.
7.	Lung X-Rays — What Is Your Diagnosis?, Florida State Board of Health, Clarence M. Sharp, M.D., Jacksonville.
8.	Otorhinologic Plastic Surgery, Maurice I. Edelman, M.D., Miami Beach.
10.	The Clinical Use of Radioisotopes, Samuel W. Root, M.D., Jacksonville.
11.	The Vaginal Approach to Pelvic Surgery, Robert W. Withers, M.D., and James M. Ingram, M.D., Tampa.
12.	Public Relations — Florida Medical Association, Edward Jelks, M.D., Jacksonville.
13.	Rehabilitation in Poliomyelitis, National Foundation for Infantile Paralysis, Miss Ruth A. Ryder, New York.
14.	Differential Diagnosis in Pulmonary Disease, Florida Trudeau Society, Rodes C. Garby, M.D., St. Petersburg.
15.	Bureau of Professional Relations, College of Pharmacy, University of Florida, Mr. Charles S. Haupt, Associate Director.
16.	Blue Shield of Florida, Inc., David R. Murphey Jr., M.D., President, Tampa.
17.	Non-Malignant Tumors of the Chest, Leffie M. Carlton Jr., M.D., Tampa.
18.	Plastic and Reconstructive Problems, Grover W. Austin, M.D., St. Petersburg.
19.	Translumbar Abdominal Aortography, Nathan Arenson, M.D., and Walter T. Colbert, M.D., Pensacola.
20.	History of Psychiatry and Its Status Today, Samuel G. Hibbs, M.D., Tampa.
21.	The Medical Examiner System in a Medium-Sized Semi-Urban County, Alfred E. Cronkite, M.D., Fort Lauderdale.
22.	Treatment of Head Injuries, C. Ashley Bird, M.D., Jacksonville.
24.	Neck Resection in Cancer of the Larynx, J. Brown Farrior, M.D., Richard A. Bagby, M.D., and Robert G. Iglesias, M.D., Tampa.
N.W. Section.	Alcohol Tests for Drinking Drivers, American Medical Association, Mr. George B. Larson, Chicago.
S.W. Section.	Nurse Recruitment and "Today's Health," Woman's Auxiliary to the Florida Medical Association, Mrs. John P. Ferrell, St. Petersburg.

CONVENTION COMMITTEES

Cabinet

N. Worth Gable, *Chairman*

George H. Anderson — Albert R. Frederick
John P. Ferrell — Chas. L. Farrington
Harry L. Allan Jr. — Richard Reeser Jr.
Edward V. Pollard — Curtis W. Bowman
Luverne H. Domeier — Whitman C. McConnell

Patio Party

George H. Anderson, *Co-Chairman*
John P. Ferrell, *Co-Chairman*

Paul F. Wallace — Daniel F. H. Murphey
George O. Wood — Samuel T. Register

Golf

Harry L. Allan Jr., *Chairman*

Joseph W. Pilkington — Richard M. Stitt
Woodrow B. Estes — Robert J. Needles

Anglers

Edward V. Pollard, *Chairman*

John H. Cordes Jr. — John P. Rowell
Bernard T. Bell

Hotels & Rates

Luverne H. Domeier, *Chairman*

Donald E. McClanathan — Harry R. Cushman
Frank L. Price — Charles K. Donegan

Greeters

Albert R. Frederick, *Co-Chairman*
Chas. L. Farrington, *Co-Chairman*

Clyde O. Anderson — Linwood M. Gable
Norval M. Marr — Everett M. Harrison
R. Wynn S. Owen — Francis H. Langley
H. Milton Rogers

Transportation

Richard Reeser Jr., *Chairman*

Robert B. Mertz — Robert J. McKeever
Carl M. Voyles Jr. — John P. Hobach

Woman's Auxiliary Advisory

Curtis W. Bowman, *Chairman*

Rowland E. Wood — Franklin W. Roush Jr.
Richard H. Sinden — Howard H. Curd

Finance

Whitman C. McConnell, *Chairman*

Alvin L. Mills — William M. Davis
Claude B. Wright — Ira C. Evans

Association Dinner

Samuel M. Day, *Chairman*

Duncan T. McEwan — John D. Milton

ALUMNI AND FRATERNITY LUNCHEONS AND SUPPERS

Monday — Soreno and Vinoy Park Hotels

THETA KAPPA PSI

12:30 p.m. Luncheon, Vinoy Park Hotel.
All attending must register with the young lady at a marked table in the lobby.

TULANE

Soreno Hotel Ballroom

6:30 p.m. Cocktails

7:30 p.m. Supper.
Brief business session, short talk by a member of the faculty of Tulane Medical School. Tulane medical students, members, wives, friends and older children invited. All attending must register with the young lady at marked table in the lobby.

TENNESSEE

6:30 p.m. Supper — Soreno Hotel, Florida Room

Jefferson

6:30 p.m. Supper — TV Room, Vinoy Park Hotel.
Speaker: Louis H. Clerf, St. Petersburg

WINNERS OF THE ORLANDO LOVING CUP

The Orlando Loving Cup was donated by the Orange County Medical Society at the Annual Meeting of the Florida Medical Association in 1931 at Orlando.

1931—Mozart A. Lischkoff, Pensacola
1932—Clarence A. Rudisill, Tampa
1933—Blackburn W. Lowry, Tampa
1934—Heyward J. Blackmon, Tampa
1935—Mozart A. Lischkoff, Pensacola
1936—Shaler Richardson, Jacksonville
1937—J. R. Chandler, Daytona Beach
1938—William Y. Sayad, West Palm Beach
1939—James T. Cowart, Tampa
1940—Lucien B. Dickerson, Clearwater
1941—William C. Roberts, Panama City
1942—Clarence A. Rudisill, Tampa
1943—No tournament (war)
1944—No tournament (war)
1945—No tournament (war)
1946—Walter C. Jones, Miami
1947—Walter F. Davey, Stuart
1948—Robert D. Harris Jr., St. Augustine
1949—Dodge D. Mentzer, Lakeland
1950—William G. Meriwether, Plant City
1951—John D. McKey, Orlando
1952—Willard F. Ande, West Palm Beach
1953—Robert C. Piper, Miami, and
Joseph W. Taylor Jr., Tampa
1954—James T. Shelden, Lakeland

WINNERS OF THE DUVAL COUNTY SOCIETY TROPHY

The Duval County Society Trophy was donated by the Duval County Medical Society at the Annual Meeting of the Florida Medical Association in 1952 at Hollywood.

1952—John D. McKey, Orlando
1953—Walter F. Davey, Stuart
1954—David W. Martin, West Palm Beach

WINNER OF THE KELEKET X-RAY AWARD

1952—James T. Shelden, Lakeland
1953— " "
1954— " "

MONDAY

FIRST GENERAL SESSION

Monday, 9:30 to 9:45 a.m.

VINOY PARK HOTEL — CONVENTION HALL

Call to Order, Duncan T. McEwan, President

Invocation, The Reverend Paul R. Hartin, D.D., Pastor, Christ Methodist Church, St. Petersburg.

Welcome to St. Petersburg, Hon. Samuel G. Johnson, Mayor.

Address of Welcome, Clyde O. Anderson, St. Petersburg, President, Pinellas County Medical Society.

Introduction Fraternal Delegates other states: J. W. Chambers, LaGrange, Ga.; R. M. Joiner, Moultrie, Ga.

Announcements

Adjournment

SCIENTIFIC ASSEMBLIES

Committee on Scientific Work: Chas. J. Collins, Chairman, Orlando; Jere W. Annis, Lakeland; Richard C. Cumming, Ocala; Arthur J. Butt, Pensacola; Donald F. Marion, Miami.

Attention is called to the following By-Laws:

"All papers read before the Association shall be its property. Every paper shall be deposited with the secretary when read."

"No address or paper before the Association, except those of the president and orator, shall occupy more than fifteen minutes in its delivery, and no member shall speak longer than five minutes, or more than once on any one subject."

FIRST SCIENTIFIC ASSEMBLY

Monday, 9:45 a.m. to 12:30 p.m.

VINOY PARK HOTEL — CONVENTION HALL

9:45 a.m. "What Is Your AMA?" Elmer Hess, President-elect, American Medical Association, Erie, Pa.

10:15 a.m. "Protein Bound Iodine — A Newer Aid in Medical Diagnosis," Nelson A. Murray, Jacksonville.
Discussion: Samuel W. Root, Jacksonville

10:45 a.m. "Diabetic Neuropathy," Richard H. Sinden, St. Petersburg.
Discussion: H. Phillip Hampton, Tampa
Joseph H. St. John, Jacksonville

11:15 a.m. Recess to Visit Exhibits

11:30 a.m. "Carcinoma of the Stomach: A Need for Earlier Diagnosis," Alton Ochsner, William Henderson Professor of Surgery and Chairman, Department of Surgery, Tulane University of Louisiana School of Medicine, New Orleans.

12:00 a.m. "Recent Advances in the Treatment of Trigeminal Neuralgia," C. Ashley Bird, Jacksonville.
Discussion: James G. Lyerly, Jacksonville
Robert G. Neill, Orlando

Scientific and technical exhibitors have arranged elaborate informational displays. Attendants will be on hand at each booth to explain their exhibits and to answer your questions.

SECOND SCIENTIFIC ASSEMBLY

Monday, 2:00 to 4:45 p.m.

VINOY PARK HOTEL — CONVENTION HALL

2:00 p.m. "The Emergency Treatment of the Injured," Peter B. Wright, Department of Orthopedic Surgery, Medical College of Georgia, Augusta, Ga.

2:30 p.m. "Mediastinal Tumors," Hawley H. Seiler, Tampa.
Discussion: DeWitt C. Daughtry, Miami
Lawrence H. Kingsbury, Orlando

3:00 p.m. "Treatment of Varicose Veins of the Lower Extremity by Stripping," James R. Anderson, West Palm Beach.
Discussion: George D. Lilly, Miami

3:30 p.m. Recess to Visit Exhibits

3:45 p.m. "Clinical Management of Peripheral Vascular Disease," Charles K. Donegan, St. Petersburg.
Discussion: C. Frank Chunn, Tampa
Mason Romaine III, Jacksonville

4:15 p.m. "Some Applications of Aortography," Ivan Isaacs, Jacksonville.
Discussion: C. Burling Roesch, Jacksonville

ALUMNI AND FRATERNITY SUPPERS

Monday, 6:30 p.m.

VINOY PARK AND SORENO HOTELS

(See page 749)



Beach and Pier, St. Petersburg

TUESDAY

FIRST MEETING HOUSE OF DELEGATES

Tuesday, 9:30 a.m.

Vinoy Park Hotel — Convention Hall

Delegates assemble at the Credentials Committee table at the end of the Palm Room near the veranda at 9:00 a.m. to present their credentials, fill out attendance cards and receive special badges from the Credentials Committee:

Louis M. Orr, Chairman
Herbert L. Bryans
Ralph W. Jack

Delegates are to occupy seats in the designated reserved section in order that they may be grouped together. Other members of the Association and guests are requested to occupy seats in other sections of the room.

9:30 a.m., President McEwan in the Chair

Parliamentarian for the President — Joseph S. Stewart

Number of eligible delegates present. Report by Louis M. Orr, Chairman, Credentials Committee

Motion to seat Delegates if a quorum is present

Adoption of minutes as published in June 1954 Journal

Recognition of Woman's Auxiliary and Other Guests

Gavel to First Vice President, V. Marklin Johnson

President's Address, Duncan T. McEwan

President Resumes Chair

Election of one Delegate and one Alternate to A.M.A. House of Delegates for two year terms beginning January 1, 1956

(Terms expiring December 31, 1955 — Delegate, Louis M. Orr; Alternate, Joshua C. Dickinson)

(A.M.A. By-Laws, Chapter IX, Sec. 1: "In order to be eligible for election to membership in the House of Delegates, a physician must have been an Active or Service Member of the American Medical Association for at least two years immediately preceding the session of the House in which he is to serve.")

Reference Committee Personnel announced by President

Presentation of Resolutions and Supplemental Reports *(Resolutions not included in House of Delegates Handbook and supplemental additions to annual reports of chairmen of committees should be typed in duplicate and placed on the Speaker's table immediately after they are presented.)*

Reports of Committee Chairmen:

(To Reference Committee No. 1)

Scientific Work, Chas. J. Collins
Medical Postgraduate Course, Turner Z. Cason
Cancer Control, Ashbel C. Williams
Venereal Disease Control, A. Buist Litterer
Tuberculosis and Public Health, John G. Chesney
Maternal Welfare, E. Frank McCall
Child Health, Warren W. Quillian

(To Reference Committee No. 2)

Conservation of Vision, G. Tayloe Gwathmey
Legislation and Public Policy, H. Phillip Hampton
Medical Education and Hospitals, Jack Q. Cleveland
Medical Economics, Robert E. Zellner
State Controlled Medical Institutions, Samuel G. Hibbs
Representatives to Industrial Council, Chas. L. Farrington
Grievance, Walter C. Payne Sr.

(To Reference Committee No. 3)

Board of Governors, Duncan T. McEwan
Necrology, Alvin L. Stebbins
Advisory to Woman's Auxiliary, Wiley M. Sams
Councilor Districts and Council, Francis H. Langley
Advisory to Selective Service for Physicians and Allied Specialists, J. Rocher Chappell
Emergency Medical Service, James V. Freeman
Resolution: Correction of objectionable recognition of irregular cults and irregular practitioners by Blue Shield of Florida, Inc. — Brevard County Medical Society

New Business

Announcements

Adjournment

SECOND GENERAL SESSION

Tuesday, 11:30 a.m.

Vinoy Park Hotel — Convention Hall

Call to Order, Duncan T. McEwan, President

Address (By Invitation), "Gallbladder Problems," Claude J. Hunt, Kansas City, Mo.

Adjournment

THIRD SCIENTIFIC ASSEMBLY

Tuesday, 2:00 to 5:15 p.m.

Vinoy Park Hotel — Convention Hall

Symposium on "The Relationship of Nutrition in Pregnancy to the Newborn," Florida Obstetric and Gynecologic Society and Florida Peditaric Society. Co-moderators, Harold G. Nix, President, Florida Obstetric and Gynecologic Society, and Lewis T. Corum, President, Florida Pediatric Society, Tampa.

2:00 p.m. Winslow T. Tompkins, Associate Professor of Obstetrics and Gynecology, University of Pennsylvania Graduate School of Medicine, Philadelphia.

2:30 p.m. Jerome S. Harris, Chairman of Pediatric Department of the Duke University School of Medicine and Duke Hospital, Durham, N. C.

3:00 p.m. Discussion

3:30 p.m. Recess to Visit Exhibits

4:00 p.m. "Reconstructive Surgery in Children," Clifford C. Snyder, Miami
Discussion: Robert Lawson, University of Miami School of Medicine
Robert F. Dickey, Miami

4:30 p.m. "Acute Renal Failure," Oscar W. Freeman Jr., Meredith Mallory, Fred Mathers and W. Dean Steward, Orlando
Discussion: William J. Dean, St Petersburg
Joseph H. St. John, Jacksonville

(Continued on page 754)


ACH



ACHROMYCIN has proved effective against:

Pharyngitis
Acute Bronchitis
Tonsillitis
Pertussis
Otitis Media
Scarlet Fever
Osteomyelitis
Epidermal Abscesses
Acute Brucellosis
Pancreatic Fibrosis
Typhus Fever
Sinusitis
Gonorrhea
Bacillary Dysentery
Pneumonia with or without Bacteremia
Bronchopulmonary Infection
Acute Pyelonephritis
Chronic Pyelonephritis
Mixed Bacterial Infections
Soft Tissue Infections
Staphylococcal Septicemia
Pneumonoccal Septicemia
Urogenital Tract Infections
Acute Extraintestinal Amebic Infections
Intestinal Amebic Infections
Subacute Bacterial Endocarditis

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A TRULY BROAD-SPECTRUM ANTIBIOTIC

Clinical research has proved ACHROMYCIN to be effective against more than a score of different infections, including those caused by Gram-positive and Gram-negative bacteria, rickettsia, certain viruses and protozoa.

In addition to its true broad-spectrum activity, ACHROMYCIN provides more rapid diffusion than certain other antibiotics, prompt control of infection, and the distinct advantage of being well tolerated by most persons, young and old alike.

ACHROMYCIN, in its many forms, was accepted by the medical profession in an amazingly short time. Each day more and more prescriptions for ACHROMYCIN are being written when a broad-spectrum antibiotic is indicated.

Lederle LEDERLE LABORATORIES DIVISION *AMERICAN Cyanamid COMPANY* Pearl River, New York

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(Continued from page 751)

REFERENCE COMMITTEES

Tuesday, 2:30 p.m.
VINOY PARK HOTEL

The three reference committees will meet on Tuesday at 2:30 p.m. The names of the delegates who have been appointed by President McEwan to serve on reference committees are listed below:

1. HEALTH AND EDUCATION
   ROOM A
   Warren W. Quillian, Chairman
   Jere W. Annis
   Frederick H. Bowen
   N. Worth Gable
   Burns A. Dobbins Jr.
2. PUBLIC POLICY
   ROOM B
   Edward Jelks, Chairman
   Walter C. Payne Sr.
   H. Phillip Hampton
   Ralph S. Sappenfield
   Francis H. Langley
3. FINANCE AND ADMINISTRATION
   TV ROOM
   John D. Milton, Chairman
   Samuel M. Day
   Francis T. Holland
   David R. Murphey Jr.
   W. Dean Steward

PATIO PARTY

Tuesday, 6:00 p.m.
VINOY PARK HOTEL — POOL PATIO

The annual Smoker has been discontinued this year and in its place will be held the Patio Party. This fellowship and cocktail hour will immediately precede the Annual Dinner and will be held on the Vinoy Park Hotel grounds in the pool area.

Tags for the Patio Party will be on sale at the registration desk ($2.50 per person). Informal entertainment appropriate to the occasion is being arranged by the local committee.



Vinoy Park Pool and Grounds

ASSOCIATION DINNER

Tuesday, 7:00 p.m.
VINOY PARK HOTEL — MAIN DINING ROOM

Master of Ceremonies, Edward R. Annis, Miami

Those who are not lodging at the Vinoy Park or the Soreno Hotels may obtain dinner tickets ($5.75 per person) from the hotel cashier.

VOUCHERS FOR PRIZES

At Association Dinner
Golf and Other Sports Events

WEDNESDAY

BOARD OF PAST PRESIDENTS

Wednesday, 8:00 a.m.
VINOY PARK HOTEL — MAIN DINING ROOM

Herbert L. Bryans, *Chairman*
Frederick K. Herpel, *Secretary*

Breakfast

Election of a Chairman and Secretary

(According to precedence, Orion O. Feaster will succeed the present chairman and Duncan T. McEwan, the present secretary.)

FOURTH SCIENTIFIC ASSEMBLY

Wednesday, 9:00 to 10:00 a.m.

VINOY PARK HOTEL — CONVENTION HALL

9:00 a.m. "Hematuria During Treatment of Malignant Hypertension with Hexamethonium Bromide," Case Report, Bernard J. McCloskey, Jacksonville.

9:15 a.m. "Systemic Blastomycosis," Case Report, Victor H. Knight Jr. and Wesley W. Wilson, Tampa.

9:30 a.m. "Contact Dermatitis," George E. Morris, Assistant Clinical Professor of Dermatology, Tufts College Medical School, Boston.

Doctor: Will you register at each booth and show your appreciation of the exhibitor's fine cooperation and costly outlay?

SECOND MEETING HOUSE OF DELEGATES

Wednesday, 10:30 a.m.
VINOY PARK HOTEL — CONVENTION HALL

Delegates sign official attendance cards at 10:00 a.m. at the table of Credentials Committee, Louis M. Orr, Chairman.

No Alternates are to be seated for Delegates attending yesterday's meeting.

President McEwan in the Chair, 10:30 a.m.

Number of eligible Delegates present. Report by Louis M. Orr, Chairman, Credentials Committee.

Recommendations of Reference Committees:
- No. 1. Health and Education
  Warren W. Quillian, Chairman
- No. 2. Public Policy
  Edward Jelks, Chairman
- No. 3. Finance and Administration
  John D. Milton, Chairman

Other unfinished business

Election of Association Officers, 12:00 noon
- President-Elect
- First Vice President
- Second Vice President
- Third Vice President
- Secretary-Treasurer
- Editor of The Journal

Dr. John D. Milton escorted to the Chair as new President

Presentation of Personal Gavel to Dr. Milton by Dr. McEwan

Presentation of Past President's Button and Certificate of Honor to Dr. Duncan T. McEwan by Dr. John D. Milton, President

Adjournment

Delegates are urged to remain in the Convention Hall for the Blue Shield of Florida annual meeting which follows immediately.

SPECIALTY GROUP MEETINGS

Saturday through Tuesday, April 2-5

Rooms have been assigned to the various specialty group societies on Saturday, Sunday, Monday and Tuesday, at the Vinoy Park and Sorento Hotels and at the Yacht Club. The State Association is not to furnish projecting lanterns or any of the equipment necessary for the holding of such meetings.

SEVENTH ANNUAL MEETING FLORIDA **ALLERGY** SOCIETY

Officers

Solomon D. Klotz, President	Orlando
W. Ambrose McGee, Vice Pres. and Pres.-elect	West Palm Beach
Edwin P. Preston, Secy.-Treas.	Miami

Sunday, April 3

Vinoy Park Hotel — TV Room

8:15 p.m.

1. "Pre-Clinical Investigations of Possible Allergens Peculiar to Sub-Tropics and Tropics. I Pollens," Mildred Fly, Department of Botany and Bacteriology, University of Miami (by invitation).
2. "Studies in the Endocrinopathic Type of Vasomotor Rhinitis. Preliminary Report," Abraham R. Hollender, Miami Beach.

   Discussion: Nelson Zivitz, Miami Beach
   Bernard M. Barrett, Pensacola
3. "Regional Factors of Importance in South Florida as Related to Allergy," Morton L. Hammond, Miami.

SEVENTH ANNUAL MEETING FLORIDA SOCIETY OF **ANESTHESIOLOGISTS**

Officers

R. Gaylord Lewis, President	West Palm Beach
Wayland T. Coppedge Jr., Pres.-elect	Jacksonville
George C. Austin, Vice President	Miami
Harry E. Bierley, Secy.-Treas.	West Palm Beach

Sunday, April 3

Vinoy Park Hotels — Room B

10:00 a.m. Business Meeting
Election of Officers

2:00 p.m. Anesthesia Study Commission Report
A study of operating room deaths. All interested physicians invited.

REGULAR MEETING OF THE FLORIDA ASSOCIATION OF **DERMATOLOGY** AND **SYPHILOLOGY**

Officers

Hollis F. Garrard, President	Miami
Joseph A. J. Farrington, Secy.-Treas.	Jacksonville

To meet at a local hospital (complete plans to be announced later).

Scientific and technical exhibitors have arranged elaborate informational displays. Attendants will be on hand at each booth to explain their exhibits and to answer your questions.

SEVENTH ANNUAL MEETING FLORIDA CHAPTER AMERICAN COLLEGE OF **CHEST PHYSICIANS**

Officers

DeWitt C. Daughtry, President	Miami
Hawley H. Seiler, Vice President	Tampa
Jack Reiss, Secy.-Treas.	Coral Gables
William L. Potts, Program Chairman	Lantana

Sunday, April 3

Sorento Hotel — Palm Room

9:00 a.m. Business Meeting

9:45 a.m. Scientific Program

1. "Carcinoma of the Esophagus," Nelson H. Kraeft, Tallahassee.
2. "Changing Laboratory Problems in Tuberculosis," Albert V. Hardy, Director of Laboratories, Florida State Board of Health, Jacksonville.
3. "Bronchoplasty in Pulmonary Tuberculosis," Ivan C. Schmidt, West Palm Beach.
4. "Cardiac Contusions," W. Dean Steward and Fred Mathers, Orlando.

12:15 p.m. Lunch

2:00 p.m. Scientific Program

5. "Mitral and Aortic Valvuloplasty," Maurice G. Buckles, Columbus, O.
6. "Some Effects of Isoniazid Therapy in Tuberculous Diabetics." Henry Meyer, Tampa.
7. "Principles of Cardiac Catheterization," Francisco A. Hernandez, Miami.

4:00 p.m. X-Ray Seminar (Those in attendance requested to bring X-Rays for discussion after presenting a *brief* and pertinent clinical history.)

All physicians of the Florida Medical Association and guests are cordially invited to attend.

NINTH ANNUAL MEETING FLORIDA ACADEMY OF **GENERAL PRACTICE**

Officers

Leonard L. Weil, President	Miami Beach
Frank T. Linz, President-elect	Tampa
Walter W. Sackett Jr., Vice President	Miami
Leon S. Eisenman, Secy.-Treas.	Hialeah

Sunday, April 3

Vinoy Park Hotel — Convention Hall

4:00 p.m. Business Session

8:00 p.m. Scientific Session: "Management of Ulcerative Colitis," Jacob A. Glassman, Miami Beach.

TENTH ANNUAL MEETING FLORIDA **HEALTH OFFICERS'** SOCIETY

OFFICERS

Thomas E. Morgan, President	Jacksonville
Clarence L. Brumback, Vice Pres.	West Palm Beach
Lorenzo L. Parks, Secy.-Treas.	Jacksonville

Monday, April 4

SORENO HOTEL — FLORIDA ROOM

9:30 a.m.

1. "Out Patient Treatment of Tuberculosis," Robert Davies, Tallahassee.
2. "Report on an Epidemic of Infectious Hepatitis," Charles H. Carter, Gainesville.
3. "Treatment of Narcotic Addiction," Mark E. Adams, Raiford.
4. "Preventative Pediatrics," David W. Martin, West Palm Beach.
5. "Do We Really Advise the Patient?" Gretchen Collins, M.P.H., Nutrition Consultant, Florida State Board of Health, Tallahassee.
6. "Report on a Poliomyelitis-like Epidemic — Tallahassee," Joseph M. Bistowish, Tallahassee.
   Discussion: Martin D. Hicklin, Montgomery, Ala.
7. "A Follow-up Study of Poliomyelitis Cases Reported in Florida in 1954," Robert Thorner, M.B.A., Statistician, Florida State Board of Health, Jacksonville.

SIXTEENTH ANNUAL MEETING FLORIDA ASSOCIATION OF **INDUSTRIAL** AND **RAILWAY SURGEONS**

OFFICERS

Plumer J. Manson, President	Miami
Frank L. Fort, President-elect	Jacksonville
W. Wardlaw Jones, Vice President	Dade City
John H. Mitchell, Secy.-Treas.	Jacksonville

Tuesday, April 5

SORENO HOTEL — PALM ROOM

3:00 p.m. Scientific Session

1. "The Future of Workmen's Compensation of Special Interest to the Industrial Physician," Mr. Rodney Durrance, Director, Workmen's Compensation Division of the Florida Industrial Commission, Tallahassee.
2. "Relation of Cardiac Conditions to Industrial Accidents or Trauma," M. Jay Flipse, Miami.
3. "Industrial Dermatoses," George E. Morris, member of the Committee on Industrial Dermatoses of both the American Medical Association and Industrial Medical Association; Assistant Clinical Professor of Dermatology at the Tufts College Medical School, Boston.

Business Session
Election of Officers

NINTH ANNUAL MEETING FLORIDA SOCIETY OF **NEUROLOGY** AND **PSYCHIATRY**

OFFICERS

Sullivan G. Bedell, President	Jacksonville
Edward H. Williams, Vice President	Miami
Roger E. Phillips, Secy.-Treas.	Orlando

Sunday, April 3

VINOY PARK HOTEL — ROOM C

2:00 p.m. Scientific Session

1. "Anxiety in Physicians," Eugene R. Shippen Jr., Orlando.
2. "Diagnosis and Management of Cerebral Vascular Accidents," William H. Everts, West Palm Beach.

Business Meeting and Election of Officers.

EIGHTH ANNUAL MEETING FLORIDA **OBSTETRIC** AND **GYNECOLOGIC** SOCIETY

OFFICERS

Harold G. Nix, President	Tampa
J. Champneys Taylor, President-elect	Jacksonville
Reuben B. Chrisman Jr., Secy.-Treas.	Miami

Tuesday, April 5

SORENO HOTEL — PALM ROOM

10:30 a.m. Business Session — Election of Officers.

11:00 a.m. Subject to be announced. Speaker: Winslow T. Tompkins, Associate Professor of Obstetrics and Gynecology, University of Pennsylvania Graduate School of Medicine.

VINOY PARK HOTEL — CONVENTION HALL

2:00 p.m. Third Scientific Assembly, Florida Medical Association. Symposium, "The Relationship of Nutrition in Pregnancy to the Newborn," sponsored jointly by the Florida Obstetric and Gynecologic Society and the Florida Pediatric Society.

Speakers: Winslow T. Tompkins and Jerome S. Harris, Chairman of the Pediatric Department of the Duke University School of Medicine and Duke Hospital.

SIXTEENTH ANNUAL MEETING FLORIDA SOCIETY OF **OPHTHALMOLOGY** AND **OTOLARYNGOLOGY**

OFFICERS

G. Tayloe Gwathmey, President	Orlando
Charles W. Boyd, President-elect	Jacksonville
Blackburn W. Lowry, 1st Vice Pres.	Tampa
Gail E. Chandler, 2nd Vice Pres.	Miami
Carl S. McLemore, Secy.-Treas.	Orlando

Sunday, April 3

VINOY PARK HOTEL — TV ROOM

10:00 a.m. Scientific Session

1. President's Address: G. Tayloe Gwathmey, Orlando.
2. "Ear, Nose and Throat Problems in Older Persons, Abraham R. Hollender and Louis G. Lytton, Miami Beach.
   Discussion: Mozart A. Lischkoff, Pensacola
   James H. Mendel Sr., Miami
3. "Evaluation of Methods in School Vision Testing," Curtis D. Benton Jr., Fort Lauderdale.
   Discussion: Marion W. Hester, Lakeland
   Kenneth S. Whitmer, Miami
4. Business Meeting
5. Annual Report of Florida Council for the Blind, Mr. Harry E. Simmons, Executive Director.

2:00 p.m. Scientific Session

1. "Classification and Mechanism in Relation to Treatment of Primary Glaucoma," Harold G. Scheie, Philadelphia, Pa.
2. "Patients with Vertigo as Seen in Daily Office Practice," Lester A. Brown, Atlanta, Ga.
3. Election of Officers

5:30 p.m. Cocktail Party — Room A

Exhibits contribute to the scientific information available at this convention.

NINTH ANNUAL MEETING FLORIDA **ORTHOPEDIC** SOCIETY

Officers

John F. Lovejoy, President	Jacksonville
Robert P. Keiser, Vice President	Coral Gables
Newton C. McCollough, Secy.-Treas.	Orlando

Monday, April 4

Vinoy Park Hotel — TV Room

10:30 a.m. Business Meeting
Scientific Meeting to follow.
Speaker: Peter B. Wright, Professor of Orthopedics, University of Georgia Medical School.

THIRTEENTH ANNUAL MEETING FLORIDA SOCIETY OF **PATHOLOGISTS**

Officers

Millard B. White, President	Sarasota
John W. Williams, Vice President	Lakeland
James B. Leonard, Secy.-Treas.	Clearwater

Sunday, April 3

Vinoy Park Hotel — Room A

10:00 a.m. General Business Session
Election of New Members
Election of Officers
2:00 p.m. Speaker: Goeffrey Mann, M.D., LLB., Chief Medical Examiner, Commonwealth of Virginia

TWENTY-SECOND MEETING FLORIDA **PEDIATRIC** SOCIETY

Officers

Lewis T. Corum, President	Tampa
Wesley S. Nock, President-elect	Coral Gables
Joel V. McCall Jr., Secy.-Treas.	Daytona Beach

Tuesday, April 5

Soreno Hotel — Florida Room

10:30 a.m. Business Session

Vinoy Park Hotel — Convention Hall

2:00 p.m. Third Scientific Assembly, Florida Medical Association. Symposium, "The Relationship of Nutrition in Pregnancy to the Newborn," sponsored jointly by the Florida Obstetric and Gynecologic Society and the Florida Pediatric Society.
Speakers: Winslow T. Tompkins, Associate Professor of Obstetrics and Gynecology, University of Pennsylvania Graduate School of Medicine, and Jerome S. Harris, Chairman of the Pediatric Department of the Duke University School of Medicine and Duke Hospital.

EIGHTH ANNUAL MEETING FLORIDA **PROCTOLOGIC** SOCIETY

Officers

Claude G. Mentzer, President	Miami
Dean W. Hart, Vice President	St. Petersburg
George Williams Jr., Secy.-Treas.	Miami

Saturday, April 2

Vinoy Park Hotel — TV Room

10:30 a.m. 1. Round Table Discussion
a. "Factors in Wound Healing," Matthew A. Larkin, Miami, Moderator.
b. "Reflex Phenomena Associated with Ano-recto-colon Disease," Ralph F. Allen, Miami, Moderator.
2. Case Reports
12:30 p.m. Luncheon — Main Dining Room
2:00 p.m. 3. "Instrument, Drug or Procedure Which Makes the Practice of Proctology Easier For Me." (Each member to participate.)
4. "Mechanical Aids in Proctologic Teaching," Mark M. Marks, Kansas City, Mo. (by invitation).

TWENTY-FOURTH ANNUAL SPRING MEETING FLORIDA **RADIOLOGICAL** SOCIETY

Officers

A. Judson Graves, President	Jacksonville
Hugh G. Reaves, Vice President	Sarasota
James T. Shelden, Secy.-Treas.	Lakeland

Saturday, April 2

Yacht Club

2:30 p.m. Round Table Discussion — Diagnosis
8:00 p.m. Dinner

Sunday, April 3

Yacht Club

9:30 a.m. Business Session and Election of Officers

ANNUAL MEETING FLORIDA CHAPTER AMERICAN COLLEGE OF **SURGEONS**

Officers

Frederick J. Waas, President	Jacksonville
Joseph S. Stewart, Vice President	Miami
C. Frank Chunn, Secy.-Treas.	Tampa

Sunday, April 3

Soreno Hotel — Florida Room

10:00 a.m. "The Value of Cholangiography During Surgery," George W. Morse, Pensacola.
"The Treatment of the Postthrombophlebitic Syndrome," Alton A. Ochsner, The Ochsner Clinic, New Orleans.

EIGHTH ANNUAL MEETING FLORIDA **UROLOGICAL** SOCIETY

Officers

Linus W. Hewit, President	Tampa
David W. Goddard, President-elect	Daytona Beach
Frank J. Pyle, Secy.-Treas.	Orlando

Sunday, April 3

Soreno Hotel — Florida Room

2:00 p.m. 1. "Ureterolithiasis: A Study of 900 Consecutive Cases," Charles Prince, Savannah, Ga.
2. Pyelogram Conference
3. Business Meeting
4. Election of Officers
5. Cocktail Party

FLORIDA **HEART** ASSOCIATION MEETING

Officers

Alvin E. Murphy, President	Palm Beach
Victor E. Kugel, President-elect	Miami Beach
William P. Hixon, Vice President	Pensacola
Daniel R. Usdin, Secretary	Jacksonville

Saturday, April 2

Vinoy Park Hotel

9:30 a.m. Room A — Committee Meetings
2:00 p.m. Convention Hall — Scientific Session
Papers on original work in the field of cardiovascular disease.
Panel discussion on "Stroke."
8:00 p.m. Room A — Committee Meetings

Doctor: Will you register at each booth and show your appreciation of the exhibitor's fine cooperation and costly outlay?

ANNUAL MEETING
FLORIDA **CANCER** COUNCIL

Ashbel C. Williams, Chairman	Jacksonville
Lorenzo L. Parks, Secretary	Jacksonville
Frazier J. Payton	Miami
George W. Morse	Pensacola
Paul J. Coughlin	Tallahassee
Wilson T. Sowder	Jacksonville
Chas. J. Collins	Orlando

Sunday, April 3
VINOY PARK HOTEL — PARLOR TO BE ASSIGNED

9:00 p.m. Business Meeting

TENTH ANNUAL MEETING
BLUE SHIELD OF FLORIDA

OFFICERS

David R. Murphey Jr., President	Tampa
Meredith Mallory, 1st Vice Pres.	Orlando
William C. Blake, 2nd Vice Pres.	Tampa
Jack O. W. Rash, Secretary	Miami
Floyd K. Hurt, Treasurer	Jacksonville

Wednesday, April 6
VINOY PARK HOTEL — CONVENTION HALL

Immediately following adjournment of F.M.A. Second House of Delegates.

TWENTY-EIGHTH ANNUAL MEETING
WOMAN'S AUXILIARY
TO THE
FLORIDA MEDICAL ASSOCIATION

HOSTESS AUXILIARY
Woman's Auxiliary to the Pinellas County Medical Society

CONVENTION COMMITTEE CHAIRMEN

Chairman and Co-Chairman	Mrs. George H. Anderson
	Mrs. Abbott Y. Wilcox
Ticket Committee	Mrs. Charles E. Aucremann
Meeting Committee	Mrs. Abbott Y. Wilcox Jr.
Decoration Committee	Mrs. Kenneth A. Baker
Transportation Committee	Mrs. Harrison G. Palmer
Exhibit Committee	Mrs. John P. Ferrell
	Mrs. N. Worth Gable
Hostess Committee	Mrs. Francis H. Langley
Golf Tournament Committee	Mrs. Harry L. Allan Jr.
	Mrs. Norval M. Marr

GENERAL INFORMATION

General Registration: will be held along with registration of members of the Florida Medical Association, Main Lobby, Vinoy Park Hotel, Sunday, Monday, and Tuesday, 8:30 a.m. to 5:30 p.m., Wednesday, 8:30 a.m. to 12:00 p.m.

Registration for Delegates, Members and Guests for the Annual Auxiliary Session: Just outside Palm Room, Soreno Hotel.

The Palm Room will be a hospitality room for the members of the Woman's Auxiliary. Coffee will be served courtesy of Mr. Martin C. McNiel, Managing Director, Soreno Hotel.

Auxiliary Meetings: All meetings of the Auxiliary will be in the Soreno Hotel.

Tickets: Annual Auxiliary Luncheon: Soreno Hotel Ballroom.

The Soreno will accept tickets from those staying at either the Soreno or Vinoy Park Hotel on American Plan. For those staying outside these hotels the price will be $3.00 including tax and gratuities. Tickets may be obtained at either the Vinoy Park or the Soreno Hotel.

Patio Party: Tickets may be obtained at the General Registration Desk, Main Lobby, Vinoy Park Hotel.

Annual Association Dinner: Tickets from the American Plan guests of either the Soreno or Vinoy Park Hotel will be honored. Other tickets available from hotel cashier.

Golf Tournament: First Golf Tournament for Ladies will be held. See information under General Convention Golf Committee.

Transportation: Shuttle busses will run at frequent intervals between the Vinoy Park and the Soreno Hotels.

Exhibit: Woman's Auxiliary Exhibit at Soreno Hotel on Nurse Recruitment and Today's Health.

AD HOC COMMITTEE CHAIRMEN

Courtesy Resolutions	Mrs. Willard E. Manry Jr.
Election	Mrs. Augustine S. Weekley
Memorial	Mrs. Lee Rogers Jr.
Reading	Mrs. Burns A. Dobbins Jr.
Secretary's Book and President's File	Mrs. Thomas C. Kenaston



Mrs. Richard F. Stover
President, Woman's Auxiliary

PROGRAM

Sunday, April 3

2:30 p.m. Pre-Convention Executive Board Meeting, Ballroom, Soreno Hotel, Mrs. Richard F. Stover, President, presiding.

Monday, April 4

9:45 a.m. First Scientific Session, Florida Medical Association, Convention Hall, Vinoy Park Hotel. Speaker: Dr. Elmer Hess, President-elect, American Medical Association. Subject: "What Is Your AMA?"

All Auxiliary members are invited to hear Dr. Hess' address. Busses will be waiting to take members to the Soreno Hotel immediately following his address.



George N. Craig, Indianapolis, Ind., Governor of Indiana; Past Commander, American Legion; Guest Speaker Auxiliary Luncheon, Soreno Hotel Ballroom, 12:30 p.m., Monday, April 4.



Mrs. George Turner, El Paso, Tex.; President, Woman's Auxiliary to the American Medical Association; Past President and Charter Member, El Paso County Medical Auxiliary; Past President, Woman's Auxiliary to the Texas Medical Association; Past Constitutional Secretary, Treasurer, and Vice President, Woman's Auxiliary to the American Medical Association; Guest Speaker, Final Session of the F.M.A. Auxiliary, Monday, April 4, Palm Room, Soreno Hotel.

10:30 a.m. Registration of Delegates, Members and Guests for Annual Session, Outside Palm Room, Soreno Hotel.

11:00 a.m. Opening Session, Annual Meeting, Woman's Auxiliary to the Florida Medical Association, Palm Room, Soreno Hotel.

Call to Order, Mrs. Richard F. Stover, President

Invocation, The Reverend Alton Glasure, Pastor, First Presbyterian Church, St. Petersburg

Address of Welcome, Mrs. Robert B. Mertz, President, Woman's Auxiliary to the Pinellas County Medical Society

Response to Address of Welcome, Mrs. Robert F. Mikell, President, Woman's Auxiliary to the Dade County Medical Association

Remarks, Dr. John D. Milton, President-elect, Florida Medical Association

Introductions, Mrs. Richard F. Stover

Introduction of Convention Chairman, Mrs. George H. Anderson, by Mrs. Richard F. Stover

Announcements, Mrs. George H. Anderson

Reading of Minutes of 1954 Annual Meeting, Mrs. Scottie J. Wilson, Recording Secretary

Roll Call of Delegates, Mrs. Scottie J. Wilson

Reports of Officers

Reports of Committee Chairmen

Reports of County Presidents
Election of 1956 Nominating Committee
Memorial, Mrs. Lee Rogers Jr., Chairman
Recess

Note: If there is no objection, the reports of all officers, chairmen and county presidents will be accepted and placed on file as printed except for such reports that require action of the convention.

12:30 p.m. Annual Auxiliary Luncheon, Ballroom, Soreno Hotel. Honoring the members of the Florida Medical Association. Guest Speaker: Honorable George N. Craig, Governor of Indiana. Luncheon adjournment promptly at 2:00 p.m.

2:15 p.m. Registration of Delegates, Outside Palm Room, Soreno Hotel

2:30 p.m. Final Session, Annual Meeting, Palm Room, Soreno Hotel
Roll Call of Delegates, Mrs. Scottie J. Wilson
Report of Registration
Election of Delegates to the National Convention
Address, Mrs. George Turner, President, Woman's Auxiliary to the American Medical Association
Unfinished Business
New Business

Courtesy Resolutions, Mrs. Willard E. Manry Jr., Chairman
Report of the 1955 Nominating Committee, Mrs. A. Fred Turner, Chairman
Election of Officers for 1955-1956
Installation of Officers, Mrs. George Turner
Presentation of Past President's Pin, Mrs. Thomas C. Kenaston, Immediate Past President
Presentation of Gavel to Incoming President, Mrs. Richard F. Stover, Retiring President
Inaugural Address, Mrs. Samuel S. Lombardo, President
Announcements
Adjournment

Tuesday, April 5

9:30 a.m. Opening Session, House of Delegates, Florida Medical Association, Convention Hall, Vinoy Park Hotel
President's Address, Dr. Duncan T. McEwan
Members of the Auxiliary Executive Board will leave immediately following address of Dr. McEwan. Busses will be available to carry them to the Soreno Hotel.

10:45 a.m. Post-Convention Executive Board Meeting, Ballroom, Soreno Hotel, Mrs. Samuel S. Lombardo, President, presiding.

All meetings will start promptly and recess or adjourn in plenty of time for the next meeting. Please cooperate by being prompt to the meetings and social events.

THE TECHNICAL EXHIBIT

One feature that always adds materially to the success of an annual meeting is the technical exhibit. Every firm represented in the display features products of particular interest to the physician. Make a special effort to visit each booth at some time during the convention and register your name with the attending representative.

The Technical Exhibit Hall will be open Sunday, Monday, and Tuesday, 8:30 a.m. to 5:30 p.m. On Wednesday it will be open 8:30 a.m. to closing time, 12:30 p.m., following which booths may be dismantled.

G. D. SEARLE & CO. — 1

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Featured will be Vallestril, the new synthetic estrogen with extremely low incidence of side reactions; Banthine, and Pro-Banthine, the standards in anti-cholinergic therapy; and Dramamine, for the prevention and treatment of motion sickness and other nauseas.

SMITH, KLINE & FRENCH LABORATORIES — 2

Featuring the diverse and dramatic uses of SKF's 'Thorazine' in arresting nausea, vomiting and hiccup, potentiating other drugs, and in psychiatric disturbances. SKF Representatives will be on hand with the latest information on 'Mio-Pressin'— the first truly "broad-spectrum" anti-hypertensive — and on the newest application of SKF's unique *Spansule* dosage form, 'Prydon' and 'Prydonnal' *Spansule* capsules, for the treatment of peptic ulcer and spastic conditions of the G.I. tract.

THE NESTLÉ COMPANY — 3

Featured in the Nestlé exhibit is Arobon, the anti-diarrheal product, prepared from specially processed carob flour. Also on display are the Nestlé infant feeding formula products — Lactogen, Dextrogen, and Pelargon. You are cordially invited to visit the Nestlé booth, where qualified representatives will be on hand to answer your questions regarding the products on display.

VANPELT & BROWN, INCORPORATED — 4

ELI LILLY AND COMPANY — 5

You are cordially invited to visit the Lilly exhibit. The display will contain information on recent therapeutic developments. Lilly sales people will be in attendance. They welcome your questions about Lilly products.

HOLLAND-RANTOS COMPANY, INC. — 6

Physicians interested in Medical Contraception are invited to discuss with H-R representatives latest information on laboratory and clinical data concerning efficacy of KOROMEX products.

WINTHROP-STEARNS INC. — 7

Hypaque sodium 50% sterile solution (ampuls of 30 cc.), new well tolerated highly radiopaque medium for excretion urography, contains 59.87% iodine. Produces excretory urograms of a clarity approaching that usually obtained by the retrograde method.

Alevaire: Nontoxic inhalant which thins sticky pulmonary secretions in bronchitis, bronchiectasis, and neonatal asphyxia.

SURGICAL SUPPLY COMPANY — 8

SCHERING CORPORATION — 9

Members of the Florida Medical Association and their guests are cordially invited to visit the Schering exhibit where new therapeutic developments will be featured.

Schering representatives will be present to welcome you and to discuss with you these products of our manufacture.

A. H. ROBINS COMPANY, INC. — 10

The A. H. Robins Company exhibit features Robalate, N.N.R.; antacid-demulcent indicated in peptic ulcer therapy and hyperacidity. The pharmaceutically elegant tablets, each containing 0.5 Gm. dihydroxy aluminum aminoacetate, are notable for exceptional palatability.

THE MEDICAL PROTECTIVE COMPANY — 11

An unparalleled record of successful malpractice protection since 1899 distinguishes The Medical Protective Company from all others. Year in and year out 99.94 per cent of its policyholders have been completely covered under $2,500. It's a sustained record that causes Medical Protective to be considered the Doctor's most secure source of security.

HOFFMANN-LA ROCHE INC. — 12

Noludar is a new, *non-barbiturate* hypnotic which provides effective relief of insomnia and tension states. Noludar is so well tolerated that side effects such as nausea, vomiting, and dizziness, are rarely, if ever experienced with therapeutic doses. Noludar is available in scored tablets of two strengths, 50 mg and 200 mg, and in a cordial-flavored elixir, 50 mg per teaspoonful.

PET MILK COMPANY — 13

We will be pleased to have you stop and discuss the variety of time-saving material available to busy physicians. Our representatives will be on hand to discuss the merits of "Pet" Evaporated Milk for infant feeding and INSTANT "Pet" Nonfat Dry Milk for special diets. A miniature can of "Pet" Evaporated Milk will be given to all visitors.

C. B. FLEET CO., INC. — 14

During the past fifty years PHOSPHO-SODA (Fleet) has been a symbol of elegance in sodium phosphate medication. FLEET ENEMA DISPOSABLE UNIT — an enema solution of Phospho-Soda (Fleet) — is a worthy companion product. The single use unit simplifies and assures satisfying preparation for proctoscopy and as a routine enema it is a boon to the hospitalized patient.

AYERST LABORATORIES — 15

Ayerst representatives will cordially welcome members of the Florida Medical Association who stop by at our booth to discuss "Premarin" or other Ayerst specialties. Physicians will also be interested in the many new developments in the Ayerst line.

BILHUBER-KNOLL CORP. — 16

The value of Oral Metrazol therapy in conjunction with your geriatric patients will be of interest to you. Your discussion of these recent developments will be welcomed. Literature and information on other prescription specialties, BROMURAL, DILAUDID, QUADRINAL, THEOCALCIN and TENSODIN as well as OCTIN and VALOCTIN will also be available and your inquiries are invited.

KELEKET X-RAY OF FLORIDA — 17

J. B. ROERIG AND COMPANY — 18

Physicians and their friends are cordially invited to visit the ROERIG booth where there will be highlighted the Company's preparations, several of which Roerig has pioneered and established for them a wide acceptance in the medical profession. ROETINIC, the new 1 a day capsule hematinic. BONADOXIN, for the prevention of nausea and vomiting of pregnancy and post operatively. ASF, Roerig's new anti-stress formula. Also available will be VITERRA, VITERRA THERAPEUTIC, AMPLUS, OBBRON, OBRON HEMATINIC and HEPTUNA PLUS. Samples and literature may be had on all products including adequate amounts for clinical trial.

EATON LABORATORIES, INC — 19

For prompt results in urinary tract infections, Furadantin® is now available in the form of tablets and as Furadantin Oral Suspension N.N.R. Within 30 minutes after ingestion of this drug, the urine becomes strongly antibacterial.

The latest dosage forms of the topical antibacterial agent Furacin® include Furacin Soluble Powder and Furacin Urethral Suppositories.

PARKE, DAVIS & COMPANY — 20

Medical service members of our staff will be in attendance at our exhibit for consultation and discussion of various products of particular interest to members of the Association. Important specialties, such as Penicillin S-R, Benadryl, Ambodryl, Dilantin Suspension, Vitamins, Oxycel, Milontin, Amphedase, Thrombin Topical, etc., will be featured. You are cordially invited to visit our exhibit.

THE S. E. MASSENGILL COMPANY — 21

PFIZER LABORATORIES 22

You are invited to visit the Pfizer booth. TERRAMYCIN INTRAMUSCULAR, CORTRIL, BONAMINE and TYZINE will be the highlights this year of a star-studded cast including the complete line of TESTED and PROVED Terramycin dosage forms, TETRACYN, the latest broad spectrum antibiotic and the Steraject line of injectable Penicillin and Combiotic preparations.

McCALL-RISING, INC. 23

The firm is certified by the American Board for Certification Prosthetic and Orthopedic Appliance Industry, Inc. Also, their Prothetist, Orthotist and Sunction Socket Fitters are certified.

McCall-Rising, Inc., is the largest prosthesis manufacturer in the States. They supply artificial limbs for lower and upper extremities in Willow Wood, Aluminum and plastics. They manufacture and supply all types of braces, either stainless steel or aluminum, according to the physicians prescription.

An invitation is extended to all to visit the facility while you are in St. Petersburg.

ABBOTT LABORATORIES — 24

Abbott Laboratories will display ERYTHROCIN, the antibiotic of wide range activity against "coccal" organisms; TRONOTHANE, Abbott's new non-"caine" topical anesthetic; BLUTENE, the non-hormonal oral drug for treatment of functional uterine bleeding; COVICONE Protective Skin Cream for protection against certain contact dermatoses; and SUCARYL, a non-caloric sweetener which has no aftertaste and is useful for diabetic and weight reducing diets. Numerous other Abbott products — nutritional supplements, antibiotics, antihistamines — will also be exhibited.

FLORIDA BRACE CORPORATION — 25

FLORIDA BRACE CORPORATION will exhibit THE JEWETT BRACE, for hyperextension of the spine (Journal of the International College of Surgeons, Volume 12, No. 4, April 1950) for the treatment of spinal conditions requiring positive hyperextension such as simple compression fractures, Osteoporosis, Adolescent Epiphysitis, and Marie Strumpell's Disease, together with modifications of the brace adapting it to post-operative use in spinal fusions.

AMES COMPANY, INC. — 26

CLINITEST, for urine-sugar analysis, is standardized. This assures uniformly reliable results whenever and wherever a test is performed — office, ward, clinic, or patient's home. Standardization not only curtails error, but saves personnel's time by elimination of preparing and mixing of reagents.

ICTOTEST, a new specific and sensitive Ames diagnostic tablet test for detection of urine bilirubin as an aid to the diagnosis and management of jaundice and hepatitis, will be on display for discussion and demonstration.

STANDARD X-RAY COMPANY — 27

CONTINENTAL X-RAY CORPORATION — 28

GUILD OF PRESCRIPTION OPTICIANS OF FLORIDA — 29

It is the purpose of the Guild of Prescription Opticians of Florida to advance the science of opthalmic optics through the development of a state-wide ethical optical dispensing service — a service that comprehensively meets the needs of the ophthalmologist and his patient. It is hoped, through the medical profession in general, to educate the public to the fact that the Ophthalmologist-Guild Optician type of eye service is the most desirable form of eye care. All of the members of the F.M.A. are cordially invited to visit us at our Booth.

(Continued on page 782)

FLORIDA MEDICAL ASSOCIATION

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The Journal of the Florida Medical Association

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Eighty-First Annual Meeting

The colorful Vinoy Park and Soreno Hotels in St. Petersburg will house the activities of the Florida Medical Association's eighty-first annual meeting, April 4-6. The Ballroom of the Vinoy Park Hotel will be known as the Convention Hall, and here will be held the two General Sessions, four Scientific Assemblies and the two meetings of the House of Delegates. The F.M.A. golf tournament will be held at the Sunset Golf and Country Club and the Lakewood Country Club. The complete program is published in preceding pages of this Journal.

This year eighteen specialty groups will meet in conjunction with the Association's meeting. Their meetings will be held from Saturday through Tuesday, at the Vinoy Park Hotel, the Soreno Hotel and the Yacht Club. This is a departure from the procedure of previous years when all specialty groups met on the Saturday and Sunday immediately preceding the Association's meeting. All of the groups who are meeting this year on days other than Saturday and Sunday are doing so voluntarily in order that the worth of the plan may be ascertained on a trial basis. The Tenth Annual Meeting of the Blue Shield of Florida has been scheduled to follow the adjournment of the Second House of Delegates on Wednesday. The Florida Heart Association will hold meetings on Saturday, and the Florida Cancer Council will meet on Sunday night. Each group has been assigned a meeting room of such size as will be adequate for the attendance anticipated. The program for each of these groups appears in this issue.

Dr. Chas. J. Collins, chairman of the Association's Committee on Scientific Work, together with the members of his committee, Drs. Jere W. Annis, Richard C. Cumming, Arthur J. Butt and Donald F. Marion, has prepared the program for the scientific assemblies. Four scientific assemblies have been scheduled, one each on Monday forenoon and afternoon and on Tuesday afternoon and Wednesday morning. At the third Scientific Assembly, a Symposium on "The Relationship of Nutrition in Pregnancy to the Newborn," will be sponsored jointly by the Florida Obstetric and

Gynecologic Society and the Florida Pediatric Society.

Dr. Duncan T. McEwan will deliver his presidential address at the first meeting of the House of Delegates on Tuesday morning. Following the meeting of the first House of Delegates on Tuesday, the guest speaker, Dr. Claude J. Hunt of Kansas City, Mo., will read his paper at the second general session.

Alumni and Fraternity Suppers will be held in the dining rooms of the two hotels on Monday night. A Patio Party will be held preceding the annual dinner which is scheduled for Tuesday night at the Vinoy Park Hotel. The Smoker on Monday night has been discontinued this year, and the Patio Party will be held in its place. In addition to participating in these social events featured annually, the members and their guests will have opportunity for diversified entertainment and recreation which will include golf, ocean and pool bathing, fishing, and sea or shore excursions.

Technical exhibits will be displayed on the veranda, in the lobby, in the Palm Room and on the mezzanine of the Vinoy Park Hotel. Scientific exhibits will be located on the mezzanine of the Soreno Hotel. They will present a wealth of information of value to specialists and general practitioners alike. The numerous technical exhibits will invite careful inspection. Attendants will be on hand at each booth to answer questions on the latest developments in equipment, drugs and other products displayed by the exhibiting firms.

Notice to Delegates and Committee Chairmen

The House of Delegates will hold its first 1955 meeting on Tuesday, April 5, at 9:30 a.m. in the Convention Hall of the Vinoy Park Hotel. The delegates are requested to assemble at the Credentials Committee table at 9:00 a.m. to present their credentials, fill out attendance cards and receive special badges. Delegates are to occupy seats in the designated reserved section in order that they may be grouped together. Other members of the Association and guest doctors are requested to occupy seats in other sections of the room.

Chairmen of standing committees are urgently requested to be present on time so that their reports may be presented as scheduled in the official program, which is published in this issue of The Journal. Resolutions not included in the House of Delegates Handbook and supplemental additions to annual reports of chairmen of committees should be typed in duplicate and placed on the Speaker's table immediately after they are presented.

The second meeting of the House of Delegates will be held Wednesday, April 6, at 10:30 a.m. Delegates are required to fill out attendance cards for this meeting at 10:00 a.m. at the entrance to the Convention Hall. These cards are the delegates' official attendance records. The By-Laws prohibit an alternate from serving for any delegate who was seated at the first meeting of the House.

At 12:00 noon on Wednesday, at this second meeting of the House, the election of officers of the Association for the ensuing year will take place.

Delegates are urged to remain in the Convention Hall for Blue Shield of Florida Annual Meeting which follows immediately.

The Malpractice Insurance Problem
IV. Plan for Improving Malpractice Insurance Experience in Florida

In the last three issues of The Journal the rising cost and other problems associated with malpractice insurance have been discussed. In an effort to solve these problems satisfactorily a plan has been proposed which will be presented to the House of Delegates for its consideration at the April meeting. Preliminary discussions have been held with a number of insurance companies, and several have expressed interest in the plan. The plan is outlined as follows with a brief discussion of each point:

1. *The Florida Medical Association will contract with one company to provide a group policy. The insurance company will issue professional liability coverage in Florida only to member physicians whose application for insurance has been approved by the Florida Medical Association.*

Any member of the Association will obviously be eligible for coverage under this plan until he has proved that he is a bad insurance risk. The requiring of Association approval of the physician applicants weeds out nonmembers and, pre-

sumably, a few members whose professional conduct constitutes an unreasonable insurance risk.

2. *The members insured under the master policy shall constitute a self-rating group, and the rates charged under the master policy shall be computed annually upon the actual loss and loss expense incurred, plus proper and agreed ratios for operating expenses and profit. There shall be no loadings in the rates for salaries, allowances, commissions, claim expense, dividends, or profit, except those contained in the predetermined and allowable expense and profit ratios, and no change shall be made in those ratios except with the approval of the Association.*

This provision gives the Association some insight into and some voice in the setting of rates. In the final analysis it is the physician himself who sets his own rates in how much he exposes himself to the possibility of suit. The insurance company merely computes the rates on the basis of loss plus costs. The Florida Medical Association will be able to ascertain whether or not costs are kept within reasonable bounds by participating in the computation of rates each year.

3. *The company shall furnish the Association, upon an approved form, analyzed loss vouchers approved by the legal counsel for the Association covering all expenditures for losses and loss expenses incurred, and no charge for closed suits and claims shall be included in the loss experience under the master policy unless covered by such a voucher.*

This provision further enhances the Association's hand in ascertaining costs.

4. *The company shall issue a certificate of insurance to any member of the Association in good standing who applies for it (unless otherwise directed by the Association) at rates approved by the Association.*

This provision protects a member of the Association from the unwarranted canceling out of his insurance.

5. *All suits and claims against members insured under the master policy shall be defended exclusively by legal counsel approved by the Association. Only an adjuster approved by the Association shall be used in the settlement of claims.*

Experience in other states has shown that malpractice suits are most successfully defended by attorneys versed in that type of case. For this reason it is deemed advisable to retain one or several lawyers to defend all cases in the state so that they will have or be able to acquire the special knowledge and background necessary in preparing a proper defense. The same reason exists for selecting one or several adjusters as does for selecting the attorney.

6. *A complete and prompt investigation of all threats of malpractice shall be made by the county society liability insurance committee with the cooperation of the insurance adjuster, and it will make recommendations as to the disposition of the case to the Association's insurance committee. The decision of the county society insurance committee may be appealed by the physician concerned or by the carrier to the Association's insurance committee. All cases shall be reported to and reviewed by the Association's insurance committee before settlement. No settlement of claims is to be made without the consent of the Association, and settlement shall be made upon recommendation of the Association.*

It is the intent of this plan that no out-of-court settlement be made in any case in which there is no merit. The reason for this is obvious. One such suit settlement in the plaintiff's favor breeds several more. Experience in other states has shown that once it became generally known that any claim of malpractice would result in a court trial, there was a sharp drop in the number of claims filed. The benefits in participating in this plan include reduced insurance rates, more adequate defense, and support of the Association; therefore, it does not seem unreasonable to expect any member threatened with suit to submit to the consensus of his counsel and the Association's malpractice defense board.

7. *The maximum coverage issued to any one physician may be limited at the option of the Florida Medical Association.*

Since this is a group plan and the cost to the individual physician is a proportionate share of the total costs, it is believed that one or several members should not be permitted to expose the group to unreasonable risk.

8. *The Association shall have the right to withdraw from a member the privilege of renewing his insurance or may cancel his insurance if it is the judgment of the Association that the medical procedure, conduct or attitude of such member constitutes an undue hazard to the group plan.*

This is a basic provision. Oftentimes it is not the conduct of the physician himself that causes a malpractice suit, but the barbed tongue of another physician. The doctor who *causes* such a suit is less entitled to insurance protection by the group plan than is the doctor who is being sued.

9. *The Association will agree to make available expert testimony from among its members. No charge will be made to the company for testimony by physicians from the community in which the physician being sued resides.*

Insurance companies have frequently had difficulty in securing expert testimony in malpractice suits. Our agreement to provide from our membership such testimony has been a strong factor in interesting insurance companies in this proposed plan. Since this is a cooperative enterprise, it is to the interest of every member of the Association to lend his assistance in every way when requested to do so.

This plan is presented not as a final answer but merely as a start toward the solution of the problem of ever rising malpractice insurance rates. Unless we are willing to help ourselves, we cannot expect insurance companies to continue to assume the risk of protecting us against malpractice claims. The plan will be subject to change as experience dictates. If it is adopted by the Association, it not only will merit but need the wholehearted support of every member of the Association to be the success we would like it to be.

EIGHTY-FIRST ANNUAL MEETING

FLORIDA MEDICAL ASSOCIATION

ST. PETERSBURG

APRIL 3-6, 1955

How Free Is Freedom?

Above the screech of brakes came the mother's cry, "Be careful! Don't get killed!"

"Why not? It's a free country, isn't it?" flung back her young hopeful, out of the wisdom of his 10 years, as he nonchalantly continued across the path of the oncoming car. Yes, this is a free country, or is it?

Here in your land and mine, how free is freedom? That is a good question at any time, but particularly so today when great segments of world population are trading liberty for security and losing both. For more than a quarter of a century, the world has been watching the passion for freedom burn low as one country after another has surrendered its liberty to some collective authority. Why this decadence of spirit? Is it simply that "freedom is difficult and slavery is easy?"

History is replete with illustrations of peoples sinking into servitude because they would not fight to stay free. Like the tramp who charted his course daily by the direction of the wind, they follow the path of least resistance. That is the perpetual lure of the totalitarian dream — food, security, the loot of empire. The price is surrender of soul, of the right to think and venture, indeed of all that has made men human.[1] To the little man who cannot face the wind in this complicated world, it is simpler to relinquish freedom, to let others think for him, to follow the straight road to tyranny.

It cannot be denied that millions of people in the world today have lost their enchantment for freedom. Some have found it too difficult, but a vast number have lost their desire for it because it has been held too lightly by those who have it, because those who have prided themselves in it have misused it. "We have used our freedom in such a way," declared John Foster Dulles, "that it seems a dangerous concept to those who have never had it, to whom it has been nothing but a word."[1] They are not impressed with our freedom. It seems incredible, but they do not want it. What an indictment of the free world.

How free is our vaunted freedom that others fear? Freedom is never absolute, of course. America's rugged individualist of frontier days now finds himself hemmed in on every side. Rugged individualism has run headlong into something more rugged than itself — into a complicated, interrelated community in which every man is

linked up with every other man. How rugged that reality is, how deeply it has challenged our traditional notions of liberty, few people have yet comprehended.[1] There are those who, while flaying Communism and Socialism, naively assume that to keep our freedom all we have to do is to get back to good old-fashioned American individualism. The physician long has been regarded as a rugged individualist of a very special sort, but would he return mentally any more than physically to the good old days of yesteryear? He is enough of a realist to know that in today's world that early individualism is as extreme on the one hand as is totalitarianism on the other. The choice is not so simple. He rejects collectivism because it exalts the state community by destruction of liberty, but he also rejects drastic individualism because it exalts liberty at the expense of community. The choice lies between them and a concept higher than both.

Freedom is of the spirit. It is free only as it serves. As its staunch exponent, the physician is peculiarly fitted by example and precept to exalt freedom in its true light. By the very nature of his profession, he serves the immediate community, appreciating that freedom is not freedom from something but freedom to something. Likewise, with its acknowledged world leadership and unequalled prestige, American Medicine is in a particularly strategic position to help dispel disillusionment with this great ideal in the world community, in which men somehow must be made free to live together in peace.

1. Hamilton, J. Wallace: Horns and Halos in Human Nature, Westwood, N. J., Fleming H. Revell Company, 1954.

Medical Emergencies and the General Practitioner

Proficiency in dealing with emergencies is the test of the good general practitioner. The requisites for correct treatment of an emergency are accurate diagnosis, calmness, judgment and experience in dealing with human beings, both patients and relatives, when they are frightened and worried.

Diagnosis is of course the cornerstone of good treatment. In an emergency, however, there is neither time nor opportunity for leisurely repeated examinations and numerous pathologic and radiologic investigations. In consequence, the physician, usually the general practitioner under such circumstances, must base his diagnosis on observations derived from the five senses alone and on correct analysis of the facts often elicited in a situation which precludes uninterrupted consideration. Importuning by distressed relatives may lead him to accede to their demand that he do something before he has weighed sufficiently the causation of the illness and the best therapeutic method to pursue.

Strength of character then is essential to the good physician who handles the emergencies of practice. In addition, he must adopt a rather different attitude of mind in the diagnosis of an emergency from that required for a slow definitive diagnosis. If he cannot arrive at a correct diagnosis with certainty, he must sort the possible pathologic lesions into those with a specific effective treatment and those without. In the latter, failure to reach a complete decision is not too important. If, however, the diagnosis falls in the first group, he may commit a grave error by overlooking or ignoring a possible cause of the condition for which therapy is available. For immediate therapy, if the choice lies between a diagnosis in either group, he should employ the specific treatment available provided it will do the patient no harm. The first principle of treatment still remains "primum non nocere." Also, recognition of precipitating factors aids prognosis and enables him to avoid making statements only to retract them later, to the impairment of his reputation.

Hayden,[1] expressing these views, outlined three steps in the art of diagnosis: (1) elicitation of facts through a good history and examination; (2) sorting out these facts into their relative importance and grouping the most important into symptom complexes; and (3) by application of a knowledge of pathology, determining of the most likely lesion to cause these symptom complexes. The first process is observational, but the other two are purely intellectual. Failure of judgment in selecting the right symptom complexes is the commonest cause of faulty diagnosis. The belief that by multiplication of facts the diagnosis will be correspondingly more accurate is the modern practitioner's most frequent error. The tendency is to rely upon numerous tests performed without knowledge of their fallibility and to accept the results of such tests above the information derived from clinical observation. From his experience in practice, it is this author's observation that some of the worst mistakes in diagnosis are made by keen individuals who pride themselves on doing their own x-ray and pathologic work, and are so obsessed with the nature of these investigations, in which they are not really competent, that they

tend to relegate to minor importance obvious clinical findings.

Many will agree with Hayden that one of the nine "don'ts" recommended by Robert Hutchison as aids to diagnosis is "Don't be too cocksure," and Cromwell's advice to the Scots leaders — "Think it possible ye may be mistaken"— is still good advice to the young diagnostician. The art of dealing with emergencies lies in establishing an accurate diagnosis, and every good general practitioner knows that the intellectual aspects of the art of diagnosis have innumerable facets.

1. Hayden, J. G.: Medical Emergencies, M. J. Australia 1:729-734 (May 15) 1954.

Bricker Amendment Again Proposed

Early in the present session of the Congress Senator Bricker introduced "S.J.RES.1. Treaties and International Agreements." This proposal of a constitutional amendment to restrict treaty-making power is identical with S.J.RES.181, introduced last August in the second session of the last Congress. The amendment would: (1) prohibit treaties made in conflict with the United States Constitution; (2) make a treaty ineffective as internal law if in conflict with state laws; and (3) require a roll call vote for ratification. Three fourths of the states would have to ratify this proposed amendment within seven years.

Senator Bricker's amended S.J.RES.1 was defeated last February in the Senate, but a shift of one vote would have given it the required two thirds. The amendment was favored by the American Medical Association and the American Bar Association and had other strong support.

The medical profession has particular interest in the Bricker amendment because it provides an important health safeguard to the profession and to the public. Under present law socialized medicine could be imposed through international treaty or agreement without enactment of domestic legislation by the House and Senate. The United States Supreme Court has under advisement a case (U. S. vs Guy W. Capps) which could have important bearing on the problem. This case concerns an Executive agreement between the United States and Canada.

Physicians need to appreciate fully the importance of this piece of legislation and to follow its progress with particular concern. It is as necessary to guard against socialized medicine from without as from within, and the profession may well keep a wary eye on both approaches. Even the old Truman-Ewing plan for national compulsory health insurance already has been placed before the new Congress. No one was surprised that the first one to introduce a bill along this line was Rep. John D. Dingell, a sponsor of the original plan. The issue is by no means dead.

Veterans Care Committee Activity

The Sub-Committee to the Board of Governors on Veterans Care has rendered yeoman's service to the Association in recent months through its efforts to carry its message directly to the membership and to feel the pulse of the members on this vitally important subject. Dr. Frederick H. Bowen, Chairman, of Jacksonville, has been particularly active in promoting the Committee's objectives by presenting an illustrated program. Since October he has addressed seven county medical societies and the Florida meeting of the American Legion. In all of the society meetings he has been assisted by Dr. James E. Cousar III of Jacksonville. Dr. George M. Stubbs, of Jacksonville, and Dr. James L. Bradley, of Fort Myers, members of the Committee, also have discussed the subject before several county societies. Dr. Bowen's plan is to visit or have Dr. Stubbs visit each county medical society in the Northeast and Northwest Medical Districts to present accurate data showing the inadvisability of continued medical care of non-service-connected disabilities by the Veterans Administration. He expects also to arrange for some member of the sub-committee or other interested physician to appear before the remaining county societies in the other two medical districts.

The objectives of the Committee's program, as set forth by Dr. Bowen, are:

"1. To inform our fellow physicians of the evils of Veteran Administration care for non-service-connected disabilities.

"2. To inform our lay citizens of this evil.

"3. To encourage our legislators to enact laws to stop the treatment of veterans by the Veterans Administration for non-service-connected disabilities."

The primary objective in making these personal presentations before the county medical societies is to get the Veterans Administration to stop treating non-service-connected disabilities. Dr. Bowen, Dr. Stubbs and Dr. Bradley have urged the doctors to try to get their patients to stop using the Veterans Administration hospitals for non-

service-connected cases. At all of these meetings they have urged the doctors to join the American Legion. Their slogan has been: "Join the American Legion and do your part in this program!"

Other Committee members are Dr. Douglas D. Martin, of Tampa, and Dr. Reuben B. Chrisman Jr., of Miami. Dr. Louis M. Orr serves as an advisory member of the Committee. At the recent Miami Clinical Meeting of the American Medical Association, Dr. Orr was appointed to a three man committee to meet with the Legion on the issue of veterans' medical care. As mentioned editorially in the January Journal, a joint Legion-A.M.A. study of veterans' hospitalization was proposed by Mr. Seaborn P. Collins, National Commander of the American Legion, in his address at the Clinical Meeting, in which he urged removal of the veterans' medical care issue "from the area of name-calling and propaganda" and declared that the Legion "neither expects nor wants the government to give carte blanche entitlement to medical care to all veterans."

University of Florida Staff Expresses Appreciation

Dean George T. Harrell Jr. and the staff of the College of Medicine of the University of Florida desire to express through the columns of The Journal their appreciation of the interest and encouragement given them by the members of the Florida Medical Association in their planning for the new College of Medicine. They wish to acknowledge publicly to the profession through this channel the generosity of the physicians in the state who have manifested their interest by voluntarily sending contributions for medical research. This spontaneous gesture has been extremely stimulating and encouraging to the entire staff.

The medical schools of this country are the keystones of national health, and their support is fundamental to the democratic tradition. This support always has come in large measure from gifts and bequests, and now is more necessary than ever before because of the vast research programs in progress. American medicine is assuming its share of the burden, contributing through the American Medical Education Foundation a little over half of the more than 2 million dollars disbursed to medical schools in July 1954. If the physicians of the country through this organization and the nation's industries through the National Fund for Medical Education continue to supplement each other's efforts, the high standard of American Medicine will continue to be upheld.

Florida medicine has shared increasingly each year in the effort to promote the cause of medical education. The American Medical Education Foundation has its 1955 campaign well underway, and physicians fortunately may earmark their contributions for the medical school of their choice. Often at this time of the year, they are considering such gifts and may overlook the privilege of designating the specific school they wish to receive them. Florida now has ample opportunity within its borders to make great strides in promoting the progress of medical education, and the physicians of the state undoubtedly will wish to have a generous share in this great endeavor.

Delegates' Report A.M.A. Clinical Meeting Miami, Nov. 29-Dec. 2, 1954

The Eighth Clinical Meeting of the American Medical Association brought to Florida and the nation's favorite resort area thousands of visitors from across the land. Held at Dinner Key Auditorium in Miami, November 29 through December 2, this outstanding medical event of 1954 in the Southeast was attended by more than 7,500 physicians and their guests. It was widely proclaimed a resounding success. Florida medicine was honored to have this great gathering in its midst and pays tribute to the Dade County Medical Association for the conspicuous manner in which it measured up to its justly celebrated role of host.

The proceedings of the House of Delegates at the Miami meeting related to many important subjects. A summary of the actions of particular general interest, issued by the Office of the Secretary of the American Medical Association, is here presented by the Delegates of the Florida Medical Association as an excellent review of those features of widest interest to the membership:

Geriatrics, medical ethics, internships, grievance committees, hospital accreditation, osteopathy, the doctor draft law, state-subsidized medicine and malpractice insurance problems were among the major subjects of discussion and action by the House of Delegates at the American Medical Association's Eighth Clinical Meeting held Nov. 29-Dec. 2 in Miami.

During the meeting the A.M.A. Board of Trustees also announced the appointment of a 13-member Commission to make a comprehensive

survey of the various types of plans through which the American people receive medical services. The Commission, headed by Dr. Leonard W. Larson of Bismarck, N. D., member of the Board of Trustees, will begin work immediately and will require at least a year to complete its survey.

Named as the 1954 General Practitioner of the Year was Dr. Karl B. Pace of Greenville, N. C., whose selection by a special committee of the Board of Trustees was announced at the opening session of the House of Delegates on Monday by Dr. Dwight H. Murray of Napa, Calif., Board Chairman. Dr. Pace received the medal and citation, presented annually for community service by a family doctor, from Dr. Walter B. Martin of Norfolk, Va., President of the American Medical Association, immediately after the announcement.

Other highlights of the opening session were addresses by Dr. Martin; Mr. Seaborn P. Collins, National Commander of the American Legion; Mrs. Oveta Culp Hobby, Secretary of Health Education and Welfare, and Mr. Edwin J. Faulkner, President of the Woodmen Accident and Life Company of Lincoln, Neb.

Mr. Collins told the House that he is willing to appoint qualified Legion representatives on a committee to take part in joint Legion-A.M.A. study of veterans' hospitalization. Later during the meeting the Board of Trustees announced appointment of a three-man committee to meet with the Legion on the issue of veterans' medical care. The members of the A.M.A. committee are Dr. Elmer Hess, Dr. David Allman and Dr. Louis Orr.

Registration toward the end of the third day of the Clinical Meeting included 3,167 physicians; 3,441 guests including residents, interns, nurses and others, and approximately 900 exhibitors and exhibitors' guests — for a grand total of more than 7,500. Final total registration at the 1953 Clinical Meeting in St. Louis was 7,716.

New A.M.A. Geriatrics Unit

The House of Delegates passed a Pennsylvania resolution which directed that the A.M.A. Board of Trustees "consider the creation of an organization on geriatrics within the present structure of the American Medical Association, the purpose of which shall be (1) to develop and assist committees on geriatrics and gerontology originating from constituent state associations and component county societies of the American Medical Association; (2) to act as a liaison between such state and county committees so there shall be a free flow of information between all levels of organized medicine on the subject of geriatrics; (3) to make available to the American people such facts, data and opinions concerning the subject of geriatrics as may be considered of value in alleviating social and medical problems created by the increasing population of older age groups; and (4) to perform such other duties as will improve and advance the medical care rendered to people of the older age group."

Medical Ethics

Accepting a recommendation in a report of the Council on Constitution and Bylaws, the House amended Section 7 of Chapter I of the Principles of Medical Ethics so that it now reads as follows on the subject of patents and copyrights:

"A physician may patent surgical instruments, appliances and medicines or copyright publications, methods and procedures. The use of such patents or copyrights or the receipt of remuneration from them which retards or inhibits research or restricts the benefits derivable therefrom is unethical."

In another action involving medical ethics, the House rejected a Kansas resolution which would have removed Section 8 of Chapter I from the Principles of Medical Ethics. The Reference Committee on Miscellaneous Business, in recommending disapproval of the resolution, said that "the American Medical Association would fail to assume a vital responsibility if no provision is included in the Principles of Medical Ethics regarding the problem of ownership of drug stores and dispensing of drugs by physicians . . . It is possible that some phases of this principle are susceptible of amendment or change, but certainly the entire principle should not be discarded."

Report on Internships

Acting on the report of the Ad Hoc Committee on Internships, the House accepted a recommendation of the Reference Committee on Medical Education and Hospitals that "the data and judgments of the Ad Hoc Committee on Internships will provide valuable guidance to the Council on Medical Education and Hospitals and with this in view it is recommended that the report be referred to the latter for their further

study and guidance." Following are a few excerpts from the report of the Ad Hoc Committee on Internships:

"It is our opinion that graduates of foreign medical schools should be considered for intern appointment in approved hospitals only when there is satisfactory evidence that:

"1. Language difficulties will not seriously impair the program.

"2. The same educational standards are applied to graduates of foreign schools as to graduates of approved American medical colleges.

"3. The appropriate state licensing board approves . . . .

"The Committee believes that the present standards detailing only the number of annual admissions, autopsy rate, number of beds and assignment of an intern to from 15 to 25 beds, are without significant meaning unless and until every local situation is reviewed 'on the grounds' and with full opportunity for discussion between the representative of the accrediting body and representatives of the hospital's governing board and its medical staff . . . .

"Had the 'two-thirds rule' remained a requirement and been rigidly applied to the two consecutive intern years 1952-3 in combination with 1953-4 it would have removed 448 hospitals, cancelled 4,205 internships to which 784 students were matched in those years and reduced the number of internships available to 6,766 . . . .

"The committee suggests consideration of some requirement based on filling a percentage of approved internships and a time limit to eliminate some of the unhealthy aspects of the present situation. The following requirement is recommended: Any internship program which in two successive years does not obtain one-fourth of its stated intern complement be disapproved for internship training.

"As applied to the figures for 1952-3 in combination with 1953-4, this requirement would have removed 277 hospitals, cancelled 2,139 internships to which 80 students were matched in those years and reduced the number of internships available to 8,832."

Grievance Committees

In order to improve efficiency and maintain high standards in the operation of grievance or mediation committees, the House endorsed the principles of two similar resolutions introduced by the Colorado and Mississippi delegations and asked the Board of Trustees to appoint a committee to study and report on recommended standards for the operation of such services. Both resolutions had emphasized the valuable public service aspects of grievance committees and had suggested that the committee appointed by the Board of Trustees be composed of representatives from constituent societies in which grievance committees have been effective and useful.

Hospital Accreditation

In place of an Indiana resolution protesting certain situations arising in connection with hospital inspections, the House adopted the following substitute resolution to resolve the problems in question:

"Resolved, that the Secretary of the American Medical Association be directed to request that the Joint Commission on the Accreditation of Hospitals supply a copy of the letter of notification regarding the results of the survey of each hospital to the Hospital Administrator, to the Chief of the Professional Staff and to the Chairman of the Governing Board of the hospital."

Osteopathy

The House concurred in the following supplementary report of the Board of Trustees on the osteopathic situation:

"Contingent on the receipt of the report from the Committee to Study the Relations Between Osteopathy and Medicine of its 'on campus' observations of osteopathic schools, the House of Delegates in June, 1954, agreed to hold in abeyance any action on this important subject until this meeting.

"The Committee, after meetings and extensive negotiations with the American Osteopathic Association, has now made final arrangements for visiting five of the six schools of osteopathy, and these plans have been approved by the Board of Trustees.

"It is the recommendation of the Board, therefore, that consideration of this matter be held in abeyance by the House of Delegates until the June, 1955, meeting, at which time the Committee expects to have a complete report of its findings concerning the nature, scope and quality of education in schools of osteopathy."

The Doctor Draft Law

The Reference Committee on Medical Military Affairs considered several reports and resolutions involving the doctor draft law, and then proposed the following policy statement which was adopted by the House of Delegates:

"(A) That on the basis of current information the House of Delegates commend and express itself as being in complete accord with the Board of Trustees and its Council on National Defense that the 'Doctor Draft Law' should not be extended after June 30, 1955, and that the House of Delegates further express its confidence in the ability of the Board of Trustees and its Council on National Defense to properly handle any new situation which may develop in regard to this highly complex and involved problem.

"(B) That the Board of Trustees and its Council on National Defense continue to study the problem of providing the best possible medical service for members of the armed forces and that they make recommendations to the Department of Defense at the earliest possible time for a more permanent solution to the problem, giving special attention to the further development of a career medical corps with adequate compensation therefor."

State-Subsidized Medicine

Most controversial issue at the Miami meeting was a resolution on "Policy on Medical Practice by Tax Supported Medical Schools," introduced by the Mississippi State Medical Association. This resolution provided that:

"The Amercan Medical Association reaffirm its unalterable opposition to socialized and state subsidized medicine regardless of the form which it may assume, and

"The House of Delegates of the American Medical Association is of the opinion that these principles should be considered by constituent and component medical societies together with all other facts pertinent to the local situation in all controversies arising in the employment of medical faculty by state (tax) supported medical schools and be fully considered in effecting action within the framework of this policy."

The Reference Committee on Medical Education and Hospitals agreed with that portion of the resolution regarding "unalterable opposition to socialized medicine" but recommended that the resolution be referred, without approval of disapproval at this time, to the Council on Medical Service which currently is studying the various aspects of this subject. The House adopted the reference committee's recommendation.

Malpractice Insurance

Two resolutions and a Board of Trustees supplementary report—all dealing with the problems and difficulties in obtaining satisfactory professional liability insurance—were considered together by the Reference Committee on Insurance and Medical Service. The House of Delegates accepted the reference committee report which said: "Inasmuch as the Board of Trustees has reported that there is in progress a study on the subject, we feel that we can well await the recommendations that the Board is planning to make at the next session. Due to the apparent emergency aspect of the problem, the Board of Trustees is urged to report to the membership as soon as possible, through its component societies, on the progress of this urgent study."

Opening Session

Dr. Walter B. Martin, A.M.A. President, declared at the opening session that "medicine belongs to the people" and physicians are "merely the purveyors" of medical care. Dr. Martin stressed that physicians have an obligation to the people that "goes beyond our own private practice and into the community," and he also emphasized the importance of "continued effort to meet the medical needs of the low-income and other non-insurable groups."

Mr. Collins, the American Legion National Commander, said that "we are citizens first and doctors and veterans second," as he urged removal of the veterans' medical care issue "from the area of name-calling and propaganda." The American Legion, he declared, neither expects nor wants the Government to give carte blanche entitlement to medical care to all veterans.

Mrs. Hobby, presenting the case for the Eisenhower Administration's health reinsurance proposal, said: "The health reinsurance proposal represents what we believe to be a necessity. It offers opportunity for self-help without subsidy." Mr. Faulkner, however, expressed the opinion that the reinsurance program, "would be foredoomed to disappoint its proponents," and he declared that voluntary health insurance can bring satisfactory protection "to practically all of our people" without a Federal reinsurance program.

Awards and Contributions

At the closing session of the House of Delegates the American Medical Association received a citation for pioneering in helping to bring educational television to the American public. James Keller, chairman of the Miami Citizens Committee for Educational Television, presented the award on behalf of the National Citizens Com-

mittee for Educational Television. Dr. Martin accepted the citation for the A.M.A.

At the same session the Utah State Medical Society, represented by Dr. George M. Fister of Ogden, presented a check for $10,355 to the American Medical Education Foundation to aid in relieving the financial plight of the nation's medical schools. The contribution was received by Dr. Louis H. Bauer, president of the foundation, who also announced that a check for $1,000 had been contributed by the Southern Medical Association.

1957 Clinical Meeting

Philadelphia was chosen as the place for the 1957 Clinical Meeting, the dates of which will be announced later. Invitations also had been received from Denver, Detroit, Mexico City and Washington, D. C. The Clinical Meeting will be held in Boston in 1955 and in Seattle in 1956.

Health Fair

As the A.M.A. Clinical Meeting came to a close on Thursday, Dec. 2, a health fair for the public opened in Miami's Bayfront Auditorium under the auspices of the Dade County Medical Society. The fair, to be open through Sunday with more than 80 exhibits featured, marks the first time that such an event has been held in connection with the A.M.A. Clinical Meeting.

Respectfully submitted,
Louis M. Orr, M.D.
Francis T. Holland, M.D.
Herbert L. Bryans, M.D.

Excellent Attendance at Midwinter Seminar

The ninth annual Midwinter Seminar in Ophthalmology and Otolaryngology was held at the Sans Souci Hotel in Miami Beach the week of January 17. There were 222 registrants at this 1955 meeting from 36 states, the District of Columbia, Puerto Rico and Canada. The states having the largest representation were Florida, 35; Pennsylvania, 19; Ohio, 18; New York, 17; Illinois, 15; and Michigan, 11. Canada and California each had 5 representatives, Washington had 2, as did Montana and North Dakota, and Oregon 1. Nationwide interest in this outstanding graduate course continues to mount each year as the attendance by states indicates. The Seminar is an important part of the Florida Postgraduate Medical Education program sponsored annually by the Department of Medicine of the Graduate School of the University of Florida.

The faculty is always outstanding. This year the lecturers on Ophthalmology were Dr. James Allen, of Tulane University of Louisiana School of Medicine, New Orleans; Dr. Milton L. Berliner, of Cornell University Medical College, New York; Dr. Walter H. Fink, of the University of Minnesota Medical School, Minneapolis; Dr. William F. Hughes Jr., of the University of Illinois College of Medicine, Chicago; and Dr. Phillips Thygeson, of Stanford University School of Medicine, San Francisco. The lectures on Otolaryngology were delivered by Dr. Lawrence R. Boies, of the University of Minnesota Medical School, Minneapolis; Dr. David D. DeWeese, of the University of Oregon Medical School, Portland; Dr. Edmund P. Fowler Jr., of Columbia University College of Physicians and Surgeons, New York; Dr. Paul H. Holinger, of Northwestern University Medical School, Chicago; and Dr. Arthur W. Proetz, of Washington University School of Medicine, St. Louis.

The annual dinner on Wednesday night at the Saxony Hotel was a popular midweek social feature with the attendance in excess of 300. It was preceded by the usual informal gathering at the cocktail hour.

Midwinter Convention of Florida Society of Ophthalmology and Otolaryngology

The eighth midwinter convention of the Florida Society of Ophthalmology and Otolaryngology was held on Wednesday afternoon, Jan. 19, 1955 at the Sans Souci Hotel in Miami Beach, with President G. Tayloe Gwathmey presiding. This year, as in previous years, the Society met in conjunction with the Midwinter Seminar in Ophthalmology and Otolaryngology sponsored by the Department of Medicine of the Graduate School of the University of Florida.

The guest speakers on the scientific program were Dr. Walter H. Fink of Minneapolis and Dr. Paul H. Holinger of Chicago. Dr. Fink's address was entitled "Pitfalls of Strabismus Operations," and Dr. Holinger's subject was "Foreign Bodies in the Tracheobronchial Tree."

The attendance was large, with many guests present. After the meeting, the members and their wives were joined by the many visiting physicians attending the Seminar and their wives at an informal gathering in the Blue Sails Room preceding the annual dinner at the Saxony Hotel, which is the major social feature of these yearly occasions.

Florida Welcomes National Otolaryngologic Societies

During the week of March 13 the nation's four outstanding otolaryngologic societies will hold their 1955 Spring Meetings at the Hollywood Beach Hotel in Hollywood. The American Laryngological Association will meet on March 13 and 14, the American Laryngological, Rhinological and Otological Society on March 15, 16 and 17, the American Broncho-Esophagological Association on March 15 and 16, and the American Otological Society on March 17, 18 and 19.

These distinguished senior specialty societies have met in the South only once before. Physicians interested in otolaryngology are privileged to attend these meetings, and all Florida otolaryngologists are invited to avail themselves of this unusual opportunity.

On the scientific program are such distinguished guest speakers as Professor Hans Selye of the University of Montreal, Dr. Edgar Frazell of the Memorial Hospital of New York, and Professor C. M. Pomerat of the University of Texas. Of particular interest will be the presentation of several candidates' theses distinguished for their excellence.

Graduate Medical Education

The Twenty-Third Annual Graduate Short Course for doctors of medicine will be held at the George Washington Hotel in Jacksonville, June 20-24, 1955. This year there are no conflicting meetings either national or in this area during these five days, and a record attendance is expected. The first three days will be devoted to Medicine, Pediatrics, and Roentgenology. The last two days will be devoted to Surgery and Gynecology. Outstanding medical teachers will deliver the lectures as in former years. Their names and subjects will appear in the April Journal, and the complete schedule will be published in the May Journal.

On June 16, 17 and 18, immediately preceding the Short Course, a two and a half day Seminar on Psychiatry for general practitioners, internists and all other nonpsychiatric specialists will be presented at the George Washington Hotel in Jacksonville. Emphasis will be placed on the early recognition of individual symptoms requiring medical attention or the aid of the psychiatrist. This course should be of wide interest to practicing physicians in many branches of medicine.

In Viewing the VA Medical Program . . .



The medical profession stands for the highest quality medical care for all citizens. Veterans, as citizens, should accept the responsibility for their own health needs—unless they became disabled as a result of military service; then it is the responsibility of the Veterans Administration to provide medical care and hospitalization. Because many communities do not as yet have adequate facilities to care for war veterans with non-service-connected tuberculosis or neuropsychiatric disorders, the medical profession recommends that the VA continue—on a temporary basis—to treat these patients.

THE SUNSHINE CITY

(Continued from page 743)

hotels. These two luxurious American plan hotels offer the members of the Association every comfort and convenience in a central waterfront location that delights the eye.

All general sessions will be held at the Vinoy Park; group meetings will be scheduled at both the Vinoy Park and the Soreno. Reservations may be made at the special convention rates for arrival as early as March 28, the opening date of the Festival of States, and convention delegates and guests may remain as long as they wish at these rates. St. Petersburg is at its best in early April and extends a traditionally hearty welcome to the Association.

OTHERS ARE SAYING

Encouraging Statistics

An interesting report was recently released by the Institute of Life Insurance showing that persons who survive a cancer operation by several years have an encouraging life expectancy. The study was made from statistics reviewed critically by the Society of Actuaries. A careful study was made of 725,000 policies covering persons with some known physical impairment, carrying through a 15 year period. Included in this study were policies on about 1,000 persons who had been operated on for cancer five years or more prior to the issuance of the policies.

Some of these people had been accepted as standard risks without extra premium and their mortality experienced was practically the same as the standard risks. Those accepted at an increased premium rate showed a death rate about twice that for the standard group, the excess mortality being due to a recurrence of cancer. The study did not show any tendency for the disease to be hereditary, following a careful study of those persons reporting a family history of cancer in any site.

Tuberculosis experience was also critically studied by the group of actuaries. In cases of persons with a history of pulmonary tuberculosis and underweight at the time the policies were issued, there was no adverse effect on mortality rates. It had been previously felt that underweight was a distinct hazard in connection with tuberculosis history. Among cases where the tuberculosis history was ten or more years prior to the issuance of the policies, the death rate for selected cases with a minimum lung involvement was about normal for those accepted at standard risks, and only slightly above normal for those accepted at extra-risk rates. Where the tuberculosis history was 6 to 10 years prior to application, the death rate was normal for standard risks and slightly increased for those who were extra-risk cases. Those accepted with a three to five year history showed a death rate about twice that of the standard. The mortality among persons with a history of chronic bronchitis was unfavorable, being about twice the normal.

This study is said to have been the most comprehensive of any previously made as it covered 132 groups of physical impairments and medical histories, further subdivided into 388 classifications. This interesting report when compared with one made 25 years previously shows that longevity had increased materially for persons with most impairments. The mortality among such persons has decreased in about the same proportion as that among standard risks during the past 15 years.

This report reflects much credit upon medical men and medical progress in recent years. It likewise should materially improve the morale of many who have an early diagnosis of many serious conditions which may be alleviated permanently by the early institution of the proper treatment.

—*The Illinois Medical Journal, October 1954*

Nursing Schools in Trouble

Much has been said and written in the last few years about the plight of our medical schools. Very little, comparatively speaking, has been said about nursing schools. We know that much effort has been directed in recent times to acquainting the people with the shortage of nurses and urging enrollment of eligible candidates in our nursing schools. It may come as a surprise to you then that our nursing schools have problems too.

Nursing schools have been too often taken for granted. Most nursing schools are associated with a large hospital, and the average physician or layman has been prone to think of them as a self-supporting adjunct to the hospital service. On the surface it would seem that this must be true. The services rendered to the hospital by the nurse in training would otherwise have to be rendered by rather highly paid employees if the student nurses were not available. Some of the instruction in the

nursing school is furnished by staff members of the hospital at no charge to the school. This, of course, is not the whole picture and the hidden expenses which are never obvious to the general public are deadly.

According to information which has reached us, cost studies at a number of the nursing schools throughout the United States have revealed that the cost of training a student nurse at most of the nursing schools is in the neighborhood of $1400 per year. This is a net cost figured after the value of the services which the nurse renders to the school or hospital has been taken into consideration. Many hospitals and universities are beginning to wonder whether or not they can afford this luxury. At this rate, a small nursing school which admits only ten new students per year would have a yearly expense of about $42,000 in operating the nursing school.

This condition has serious portent. Already it has been reported that one of the largest and best known universities of the South has closed its nursing school. Only recently, one of the hospitals in Phoenix decided not to take a freshman class of nurses, probably as the first step toward closing its nursing school. There is no reason to believe that other nursing schools may not follow these examples. This in the face of increasing publicity urging young women of America to adopt nursing as a career.

The matter should concern every physician and every citizen of our country. The solution to the situation should be sought now and applied as soon as available.

—Arizona Medicine, October 1954

BIRTHS AND DEATHS

Births

Dr. and Mrs. Bernard B. Seltzer of Hollywood announce the birth of a daughter.

Dr. and Mrs. Daniel O. Hammond of Miami announce the birth of a daughter, Helen Paulson, on Dec. 25, 1954.

Dr. and Mrs. Aron N. Gillman of Miami announce the birth of a daughter, Susan Mary, on Dec. 29, 1954.

Dr. and Mrs. Richard L. Foster of Fort Lauderdale announce the birth of a daughter, Rachel Ann, on Jan. 2, 1955.

Deaths — Other Doctors

Watson, Rudolph B., Washington, D. C. Oct. 15, 1954

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Akey, Robert N., Lakeland
Beeler, Robert V. Jr., Bradenton
Buchwald, Merwin E., Fort Myers
Buford, Coleman G., West Palm Beach
Clayton, James M. Sr., Lakeland
Deal, Dwayne L., Dade City
Dillon, Charles F. Jr., Orlando
Dorr, Thomas W., Tampa
Fiero, Rollin P., Daytona Beach
Ford, J. Arthur, Winter Park
Gatliff, Benjamin F., Plant City
Gibson, William J., St. Augustine
Grawey, Gerald W., Brewster
Gryte, Lewis A., Clearwater
Hinton, Forrest, Immokalee
Hodge, Edgar B., Lake Alfred
Hubbell, David S., St. Petersburg
Jackson, Kenneth W., Lake Alfred
Lucas, Howard C., Winter Haven
Magnon, West B., Tampa
Medlock, Frederick E. Jr., Orlando
Millikan, William J., Fort Lauderdale
Morrison, Charles W., Key West
Mott, Richard H. Jr., Frostproof
Myhree, Earl P., St. Petersburg
Parks, Charles T., Winter Haven
Pattengale, Nell T., St. Petersburg
Permesly, Harry M., Hollywood
Pickering, James A., Pompano Beach
Price, Walter C., Lakeland
Ramel, William J., Hollywood
Rast, Charles L. Jr., St. Petersburg
Segal, Milton, St. Augustine
Simkus, Albert A., Bradenton
Stephens, Wade N., Orlando
Vale, H. E. Peter, Daytona Beach
Welsh, Russell L., New Smyrna Beach
West, James L. Jr., St. Petersburg
Wood, Frederic H., Bradenton
Young, Clifton A., Dunedin

CORRESPONDENCE

Artificial Insemination in Florida

Honorable Richard W. Ervin
Attorney General
State of Florida
Office of the Attorney General
Tallahassee, Florida

Re: Artificial insemination in Florida

Sir:

Reference is made to your letter of October 27 enclosing a letter from Dr. J. Laxton Watson, 1426 Northwest 163rd Street, North Miami Beach, Florida.

I would appreciate having your opinion as to whether artificial insemination is legal in the State of Florida provided written consent is obtained from both husband and wife.

Very truly yours,
(Signed) Wilson T. Sowder, M.D.
State Health Officer

WTS: ch
cc—Dr. J. Laxton Watson
Jacksonville, Florida
November 23, 1954

Dr. Wilson T. Sowder
State Health Officer
State Board of Health
P. O. Box 210
Jacksonville 1, Florida

Re: Artificial Insemination

Dear Doctor:

This will acknowledge receipt of your letter of November 24, 1954, in the above matter.

Please be advised that Florida has no statute authorizing the procedure of artificial insemination, nor does it have a statute prohibiting such procedure. However, this practice is no longer a novel procedure. It is reported that by 1941 almost 10,000 pregnancies had occurred in the United States as a result of artificial insemination. and it is reasonable to assume that many more such pregnancies have occurred in the United States since that date. Notwithstanding this fact. there is little that can be said with any degree of assurance concerning the legal aspects of the artificial insemination procedure. The legal aspects of this procedure have not been determined by any court of appellate jurisdiction in the United States.

The legal questions that may arise concerning artificial insemination are many and complex and are unknown to the common law, and such questions are not covered by specific statutory provisions in any state of the United States. Some of the most grave questions are those relative to adultery, legitimacy. inheritance and liability in connection with the selection of donors for this operation.

The practice of artificial insemination is frowned upon as against public policy in most states which commented upon this practice. Five states, in the years of 1948 and 1949, have attempted and failed to enact laws on this procedure. The one thing in common among the proposed laws of each of the five states was a provision to make legitimate a child born as a result of such procedure. (See Journal of the American Medical Association, September 15, 1951, at pages 250-253 and other authorities there cited.)

Because of the many serious legal questions surrounding the procedure of artificial insemination, it is impossible to predict the legal consequences of such a procedure with any degree of assurance. However. it appears that the grave legal problems which might be confronted by a child born of this procedure would cause a prudent and cautious person to recognize such a practice to be against public policy and frowned upon.

Sincerely,
(Signed) Richard W. Ervin
Attorney General

RWE/JEW/wk
Tallahassee. Florida
December 14. 1954

This Journal contains

the complete program

for the

EIGHTY-FIRST

ANNUAL MEETING

at St. Petersburg

April 3–6, 1955.

Medical Officers Returned

Dr. Cullen W. Banks II, who entered military service on May 22, 1953, was released from active duty on Sept. 21, 1954 with the rank of captain, U. S. Army. His address is 635 N.W. 6th St., Gainesville.

Dr. Bernard A. Kaminski, who entered military service on Nov. 9, 1952, was released from active duty on Nov. 8, 1954 with the rank of captain, U. S. Air Force. His address is 1039 duPont Bldg., Miami.

Dr. William J. Knauer Jr., who entered military service on Nov. 17, 1952, was released from active duty on Nov. 16, 1954 with the rank of captain, U. S. Army. His address is Johns Hopkins Hospital, Baltimore.

Dr. Charles H. Gilliland, who entered military service on July 10, 1942, was released from active duty on Nov. 30, 1954 with the rank of commander, U. S. Navy. His address is 921 S.W. 2nd Ave., Gainesville.

Dr. J. P. Cole, who entered military service on Oct. 27, 1952, was released from active duty on May 5, 1954 with the rank of lieutenant, U.S.N.R. His address is Scripps Metabolic Clinic, 476 Prospect, LaJolla, Calif.

Dr. Meredith Mallory Jr., who entered military service in January 1945, was released from active duty on Nov. 3, 1954 with the rank of lieutenant colonel, U. S. Army. His address is 1909 Alamo National Bldg., San Antonio, Tex.

Dr. Edward L. Cole Jr., who entered military service on Jan. 6, 1953, was released from active duty on Jan. 6, 1955, with the rank of lieutenant, U.S.N.R. His address is 1801 16th St. N., St. Petersburg.

Dr. L. Wayne Johnson, who entered military service on Jan. 17, 1953, was released from active duty on Jan. 17, 1955, with the rank of captain, U.S.A.F. His address is 212 First St. N., St. Petersburg.

Dr. Rex B. Perkins, who entered military service on Aug. 1, 1952, was released from active duty in February 1954, with the rank of captain, U.S. Army. His address is 502 Devon, Birmingham, Ala.

Dr. Frank B. Hodnette, who entered military service on Feb. 23, 1953, was released from active duty on Feb. 22, 1955, with the rank of captain, U.S.A.F. His address is 1750 N. Palafox St., Pensacola.

STATE NEWS ITEMS

The many friends of Dr. Wilburt C. Davison, Dean and Professor of Pediatrics, Duke University School of Medicine, will be pleased to learn that he will give the lectures on Pediatrics at the Twenty-Third Annual Graduate Short Course. His lectures will come the first three days of the Short Course, June 20, 21 and 22, 1955.

Dr. Hawley H. Seiler of Tampa was elected secretary of the Southern Thoracic Surgical Association at its recent meeting in Hollywood.

The 1955 meeting of The American Goiter Association will be held at the Skirvin Hotel in Oklahoma City, April 28-30. The program will consist of papers and discussions dealing with the physiology and diseases of the thyroid gland.

A short intensive course on the laboratory diagnosis and pathology of parasitic infections will be presented Aug. 15-27, 1955, at the Louisiana State University School of Medicine in New Orleans.

The course is designed primarily for pathologists and technologists. It will include lectures, extensive demonstrations, films and supervised individual laboratory study. Emphasis will be placed upon the practical aspects of laboratory diagnosis of common parasitic infections, including training in stool examination and stool concentration technics. Abundant material from patients with parasitic diseases endemic in this area will be available for examination. Comprehensive slide sets containing parasitic organisms in tissue sections will be studied. Library facilities are available. The medical school building is air conditioned.

Registrants should bring their microscopes, equipped with mechanical stages, and their microscope lamps. A limited number of places will be available. The fee for the course is $50. Persons interested in attending should write to Dr. Clyde Swartzwelder, Department of Microbiology, Louisiana State University School of Medicine, 1542 Tulane Ave., New Orleans 12.

Dr. Theodore W. Weeks Jr. of Sebring recently attended a public health officers school at the University of Florida.

Dr. Emil M. Isberg of Miami spoke at the January 10 meeting of the Mental Health Society of Southeast Florida.

Dr. Samuel J. Alford Jr. of Jacksonville was elected vice president, and Dr. John J. Fisher, a member of the executive committee of the Jacksonville Police Pistol Club.

Recently installed officers in the Riverside Presbyterian Church of Jacksonville were Drs. Leo M. Wachtel, elder; Vernon T. Grizzard, deacon; Robert G. Cushman and Thad Moseley, ushers.

Dr. Paul F. Baranco of Pensacola has been named president of the Greater Pensacola Community Chest for 1955.

Dr. Lorenzo L. Parks of Jacksonville spoke at a meeting of cancer workers in Fort Myers in January.

Dr. H. John Richmond of Lake Worth spoke on discipline for children at a meeting of the Junior Women's Club in January.

Dr. John J. Fisher of Jacksonville gave a talk on polio and its effects at a January meeting of the Atlantic Beach Elementary School P.-T.A.

Dr. Jere W. Annis of Lakeland spoke on the heart at a meeting of the Haines City Woman's Club in January.

Dr. H. Marshall Taylor of Jacksonville attended the meeting of the Council of the American Laryngological Association in New York on January 8.

Dr. Fred F. Porter, formerly of Titusville, entered medical service with the U.S. Air Force on Oct. 11, 1954, with the rank of first lieutenant. He is stationed at Base Hospital, Turner AFB, Albany, Ga.

Dr. Karl B. Hanson of Jacksonville spoke on "Heart Disease and the Duval District Heart Association" before the January meeting of the St. Vincent's Hospital Auxiliary.

Dr. Lorenzo L. Parks of Jacksonville has been made a colonel in the Medical Corps of the Florida National Guard.

The Florida Society of Medical Technologists will meet in Tampa at the Hillsborough Hotel, April 1-3. Guest speakers who will appear on the program on Saturday, April 2, are Dr. F. S. Cheever, Professor of Microbiology at the University of Pittsburgh, who will speak on "General Principles of the Laboratory Diagnosis of Viral Infections"; Dr. Ann S. Minot, Department of Biochemistry of the School of Medicine of Vanderbilt University, "The Electrolyte Chemistry in Clinical Medicine;" and Dr. Samuel W. Root of Jacksonville, "Uses of Radioisotopes in Hematology." All interested doctors are invited to attend this meeting.

Dr. Hugh A. Carithers of Jacksonville has been reappointed to the Florida Children's Commission by Governor LeRoy Collins.

Dr. Nathaniel Jones of Jacksonville has been appointed senior warden of the Grace Episcopal Parish of that city.

On Jan. 16, 1955 the Florida Council for the Blind held its semiannual meeting at the Sans Souci Hotel in Miami Beach. Members of its medical advisory committee who attended were: Drs. Nathan S. Rubin, Pensacola, chairman; Charles C. Grace, St. Augustine; Carl S. McLemore, Orlando; Shaler Richardson, Jacksonville; and William Y. Sayad, West Palm Beach. Dr. Sherman B. Forbes, of Tampa, the remaining member of the committee, was unable to attend because of illness. Dr. Kenneth S. Whitmer, of Miami, was added to the committee at this meeting.

COMPONENT SOCIETY NOTES

Brevard

At the regular meeting of the Brevard County Medical Society on January 13, guest speakers were Drs. Truett H. Frazier and A. Fred Turner Jr. of Orlando who spoke on urological problems in general practice.

Columbia

The Columbia County Medical Society has paid 100 per cent of its state dues for 1955.

Dade

The regular meeting of the Dade County Medical Association was held on February 1. Dr. Morton M. Halpern spoke on "Activities of the Heart Association," and a film on "Diagnostic Tests in Peripheral Arterial Disease," sponsored by the American Heart Association, was shown.

DeSoto-Hardee-Highlands-Glades

The regular dinner meeting of the DeSoto-Hardee-Highlands-Glades County Medical Society was held in Wauchula on February 1. Guest speaker was Dr. Thomas G. Dickinson of Sarasota who spoke on ocular diseases and emergencies. His talk was illustrated with slides.

Duval

At the regular meeting of the Duval County Medical Society on February 1. Dr. Michael E. DeBakey, professor of surgery at the Baylor University School of Medicine, spoke on "The Use of Blood Vessel and Plastic Grafts in Lesions of the Aorta and Major Arteries."

Franklin-Gulf

The Franklin-Gulf County Medical Society has paid 100 per cent of its state dues for 1955.

Hillsborough

The regular monthly meeting of the Hillsborough County Medical Association was held on February 1 at the Floridan Hotel in Tampa. The program was on "Public Service" and the guest speaker was Dr. Julian P. Price of Florence, S. C., a member of the A.M.A. Board of Trustees.

Marion

At the regular meeting of the Marion County Medical Society on January 18, Dr. William H. McCullagh of Jacksonville was guest speaker.

Volusia

The Volusia County Medical Society sponsored Medical Forum Programs in Daytona Beach and DeLand. Subjects of the Forums and the dates they were given are as follows: "Heart and Hardening of the Arteries," January 31; "High and Low Blood Pressure," February 7; "Kidney, Bladder and Prostate," February 14; and "The Use and Abuse of Vitamins," February 21.

Walton-Okaloosa

The Walton-Okaloosa County Medical Society has paid 100 per cent of its state dues for 1955.

WANTED — FOR SALE

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

GENERAL PRACTICE: Associate. Well established general practitioner with rapidly expanding practice in major West-Coast Florida industrial city desires young associate. Must have Florida boards. Once-in-a-lifetime opportunity for right man. Personal detail and photo must accompany reply. Write 69-144, P.O. Box 1018, Jacksonville, Fla.

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GENERAL PRACTITIONER: Miami, Florida, called to military service. Locumtenens or partner wanted for established general practice on percentage basis. Leaving April thirtieth. Write 69-147, P.O. Box 1018, Jacksonville, Fla.

OFFICE FOR RENT: Office space for rent in Clearwater, Florida. Contact doctor's widow, Mrs. T. R. Purcell, 105 South Lake Drive, Clearwater.

DOCTOR'S OFFICE: Have two offices. Will sublease Lincoln Road office, or rent same, afternoons. Practice established many years. Hospital connections. Write or Wire Box 695, Miami Beach.

PATHOLOGIST: 44, Certified anatomic and clinical pathology. Florida license. Desires hospital affiliation. Write 69-148, P.O. Box 1018, Jacksonville, Fla

(Continued from page 761)

GERBER PRODUCTS COMPANY — 30

WHEN MILK IS CONTRAINDICATED as the basic food for infants, Gerber's "Meat Base Formula" can provide a nutritionally adequate replacement. It is well accepted and tolerated by infants of all ages. Your Gerber detailman invites you to evaluate "Meat Base Formula" and the complete line of supplementary baby foods.

You are also invited to review new editions of Gerber's baby care and adult special diet booklets. Each is designed especially for distribution by physicians. Each provides non-controversial information in simple, easy-to-understand language. The service is complimentary.

J. A. MAJORS COMPANY — 31

The W. B. Saunders Company, Medical Publishers, of Philadelphia through their Southern agents J. A. Majors Company will occupy this space. Many new books will be on exhibit. Those specially featured are: Shackelford's "Surgery of Alimentary Tract," 3 vols; Ochsner & DeBakey's New 7th Edition of Christopher's MINOR SURGERY; Conn's "Current Therapy 1955;" Allen, Barker, and Hines' "Peripheral Vascular Diseases," 2nd Edition; Greenhill's "Obstetrics," New 11th Edition; Alexander's "Drug Therapy;" and many others.

WHITE LABORATORIES, INC. — 32

A. S. ALOE COMPANY — 33-34

A cordial welcome is extended to the members of the Florida Medical Association to visit the A. S. Aloe Company exhibit. A unique array of Surgical, Physio-Therapy, X-Ray and Laboratory equipment will be displayed.

THE COCA-COLA COMPANY — 35-36

SHARP & DOHME — 37

The many indications for 'Hydrocortone' or 'Cortone' highlights the therapeutic importance of these hormones in everyday practice. A new anesthetic agent 'Cyclaine' Hydrochloride with qualities suitable for such forms of regional anesthesia as infiltration, nerve block, spinal, caudal, and topical is of interest. Research data relative to more effective therapy when penicillin is used in conjunction with 'Benemid' completes the exhibit. Expertly trained personnel solicit discussions on these observations.

TABLEROCK LABORATORIES, INC. — 38

New Tablerock products, and new brochures of useful interest to you on products already introduced, will be featured at our booth. As in former years, your Tablerock Representatives again cordially invite you to visit the Tablerock Booth.

GENERAL ELECTRIC COMPANY, X RAY DEPT. — 39

SURGICAL EQUIPMENT COMPANY — 40-41

The Surgical Equipment Co., Miami, Florida, cordially invites you to visit their booths where the latest equipment and instruments are on display.

PARCO SURGICAL SUPPLIES — 42

You are cordially invited to visit Parco's booth. Items of interest will be displayed with competent representatives in attendance.

BRAYTEN PHARMACEUTICAL COMPANY — 43

Brayten Pharmaceutical Company will feature its superior antacid tablets, ALGLYN, BELGLYN, and MALGLYN COMPOUND at the Brayten Booth. Literature and reprints will be available at the booth and an interesting demonstration will be given on request.

THE WM. S. MERRELL COMPANY — 44

TACE, the unique non-steroid developed by Merrell, *offers a new approach to the treatment of the menopause.*

TACE is temporarily stored in body fat, and released over an extended period of time. One course of TACE therapy is generally all that is required to ease many patients into the symptom free postmenopausal period. Symptom relief is excellent, and side effects are virtually absent.

Merrell professional service representatives will be present to answer any questions you may have concerning this new and distinctive estrogen. They will be happy to discuss other Merrell specialties as well.

MALTBIE LABORATORY DIV., WALLACE & TIERNAN INC. — 45

ROWLAND LABORATORIES — 46-47

MEAD JOHNSON & COMPANY — 48

Mead Johnson & Company — ethical manufacturers of Infant Nutrition products featuring liquid & powdered LACTUM, formulas meeting the modern concept of infant feeding, POLY-VI-SOL, TRI-VI-SOL AND PABLUM Cereals.

ANDERSON SURGICAL SUPPLY CO. — 49

The Anderson Surgical Supply Co. will exhibit the Burdick Electro-cardiograph, a new Aspirating pump, and a Devilbiss pressure unit, as well as a number of other specialty items.

CIBA PHARMACEUTICAL PRODUCTS, INC. — 50

THE BORDEN COMPANY — 51

There's no better place to talk over the latest information on infant feeding than the Borden Prescription Products booth. On display is the complete line of Borden's infant formula products for every feeding purpose or preference. You can feed almost any baby BREMIL, MULL-SOY (Liquid or Powdered), DRYCO, or BIOLAC.

MEDICAL SUPPLY COMPANY — 52

Visit our Booth for Ultrasonic Information. Burdick Cardiograph Machines and Ritter Tables.

CARNATION COMPANY — 53

Carnation Company is pleased to present the first Instant Nonfat Dry Milk. You are cordially invited to visit with us and to sample this miracle product . . . the greatest advance in the dairy industry since homogenization. You'll like its fresh milk flavor. . . . it dissolves instantly, even in ice water. An excellent, economical source of protein: useful in diets for weight reduction, high protein, undernutrition, pregnancy and geriatrics.

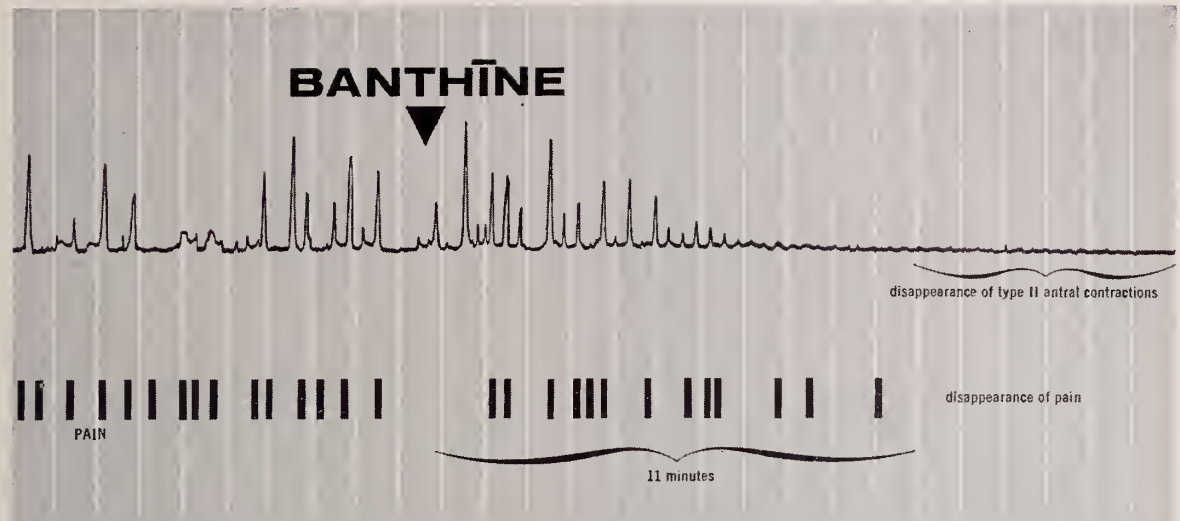
ORTHO PHARMACEUTICAL CORPORATION — 54

ORTHO cordially invites you to this booth where the well known line of obstetrical and gynecological pharmaceuticals will be on display. Particular emphasis will be placed on Ortho preparations for conception control. Ortho representatives will be on hand to offer pertinent information on their products.

IVES-CAMERON COMPANY, INC. — 55

We are proud to exhibit MONICHOL, the first satisfactory medication for the normalization of elevated serum cholesterol levels as associated with cardiovascular disease, diabetes, etc. Ask our representatives for information on DUOTINIC, OXSORBIL, PABASYL and MUCARA, other outstanding Ives-Cameron specialties.

BANTHĪNE® IN PEPTIC ULCER



Effect of 100 mg. of Banthīne administered orally on antral gastric motility and duodenal ulcer pain.

Hightower, N. C., Jr., and Gambill, E. E.: Gastroenterology 23:244 (Feb.) 1953.

Hypermotility and Hyperacidity

A recent evaluation of anticholinergic therapy in peptic ulcer emphasizes the fact that now the profession has at its disposal agents that are "effective in reducing both secretory and motor activity of the stomach."

The effect on motor activity is generally more pronounced and less variable than on secretion; pain relief is usually prompt; a high degree of effectiveness is noted in ambulatory ulcer patients.

Ruffin, J. M.; Texter, E. C., Jr.; Carter, D. D., and Baylin, G. J.: J.A.M.A. 153:1159 (Nov. 28) 1953.

With its proved anticholinergic effectiveness, Banthine has been found extremely useful in the medical management of active peptic ulcer, whether duodenal, gastric or marginal.

The immediate increase in subjective well-being and the simplicity of the Banthine regimen assures patient cooperation. The recommended initial therapeutic dose is 50 or 100 mg. (one or two tablets) every six hours around the clock, with subsequent individual adjustment. The usual measures of diet regulation, rest and relaxation should be followed.

Banthine is effective in other conditions caused by excess parasympathetic stimulation. These include hypertrophic gastritis, acute and chronic pancreatitis, biliary dyskinesia and hyperhidrosis. Banthine is contraindicated in the presence of glaucoma and should be used with caution in the presence of severe cardiac disease or prostatic hypertrophy.

Banthine bromide (brand of methantheline bromide) is supplied in scored tablets of 50 mg. and in ampuls of 50 mg. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co. Research in the Service of Medicine.

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Tuckahoe, New York

RIKER LABORATORIES, INC. — 56

WALKER LABORATORIES, INC. — 57

PRECALCIN and PRECALCIN LACTATE will be featured at the WALKER booth. PRECALCIN is the original dietary adjunct supplying comprehensive vitamins and minerals for use during pregnancy and lactation. The new PRECALCIN LACTATE product is the same as the original PRECALCIN except for the source of calcium which is the lactate instead of the phosphate. By providing both forms, the doctor may have his choice of calcium sources to suit individual patient requirements.

PICKER X-RAY CORPORATION — 58

E. R. SQUIBB & SONS 59

PAUST MANUFACTURING CO. — 60

Physical Therapy and Rehabilitation Equipment will be demonstrated including The Paust Electronic Stimulator Model 50-C. Put employees — patients — claimants back to work quicker; reduce the malingers; adjunct therapy in strains, sprains, dislocations and other trauma of the musculoskeletal system; muscle atrophy, need of muscle re-education and re-establishment of muscle sense. Buy a precision engineered muscle stimulator with a guarantee assured by 35 years in electronics. More doctors use electrical muscle stimulators made in the Paust plant than all others together. Visit our booth.

SANDOZ PHARMACEUTICALS — 61

Sandoz Pharmaceuticals cordially invites you to visit our display.

FIORINAL a new approach to therapy of tension headaches and other head pain due to sinusitis and myalgia.

PLEXONAL Sandoz introduces a new sedative-hypnotic — Plexonal. This exhibit demonstrates that Plexonal is not just another sedative, but is one developed on a new pharmacologic approach. The action of subthreshold doses of classic sedative agents are potentiated and enhanced by autonomic and central acting drugs.

BELLERGAL Time-tested and clinically proven as a potent autonomic inhibitor in a variety of psychosomatic disorders. Supporting clinical evidence will be presented.

ACYLANID has all the *advantages* of digitoxin but the *safety* of whole leaf digitalis.

Our representative, Mr. Leo Bruce will gladly answer questions about these and other Sandoz products.

EXECUTONE, INC. — 62

Executone communication equipment specially designed for doctors' offices and clinics will be displayed for the third consecutive year at the St. Petersburg Convention, on the Mezzanine Floor. Many doctors are using Executone equipment to save them time, steps and to expedite the flow of patients throughout their offices. Executone is represented on the West Coast by Chamberlain's Audio Products, 404 Eunice St., Tampa, Florida; in the central part of the State by Executronics, 423 S. Orange, Orlando, Florida; in the northern part of the state by Southern Distributors, 2072 Liberty, Jacksonville, Florida, and in southern Florida by J. M. Coker & Associates, 224 Alcazar, Coral Gables, Florida.

EISELE & COMPANY — 63

THE UPJOHN COMPANY — 64

Members of the medical profession are invited to visit the Upjohn booth where members of The Upjohn Company professional detail staff are prepared to discuss subjects of mutual interest.

R. J. REYNOLDS TOBACCO COMPANY — 65

Welcome to the R. J. Reynolds Tobacco Company Exhibit! You are cordially invited to receive a cigarette case (monogrammed with your initials) containing your choice of CAMEL, CAVALIER King Size, or WINSTON, the distinctive new king size, filter cigarette.

BURROUGHS WELLCOME & CO. (U.S.A.) INC. — 66

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No dilution required

For intramuscular or intravenous use

Digoxin 'B. W. & Co.' is also available as tablets for oral digitalization.

'NEOSPORIN'® brand Polymyxin B — Bacitracin — Neomycin

ANTIBIOTIC OINTMENT, for treatment of topical bacterial infections with minimal risk of sensitization

'MAREZINE'® Hydrochloride brand Cyclizine Hydrochloride — Oral

For prevention and treatment of nausea and vomiting of pregnancy, motion sickness and vertigo.

Also available *for injection* in postoperative vomiting.

SHERMAN LABORATORIES — 67

ENCYCLOPEDIA AMERICANA — 68

All members and guests are invited to inspect the 1955 Edition of the Encyclopedia Americana, finest in our 126 year history and highly endorsed by the State Library Board and the Department of Public Instruction of the State of Florida. Also on display will be the Heritage Edition of the Book of Knowledge for Children. All those registering at our Booth will receive a beautiful 48 page World Atlas in full color with our compliments.

(Continued on page 787)

Results With

'ANTEPAR'®*

against PINWORMS

In clinical trials, over 80% of cases have been cleared of the infection by one course of treatment with 'Antepar.'

Bumbalo, T. S., Gustina, F. J., and Oleksiak, R. E.:
J. Pediat. 44:386, 1954.

White, R. H. R., and Standen, O. D.:
Brit. M. J. 2:755, 1953.

against ROUNDWORMS

"Ninety per cent of the children passed all of their ascarides . . ."

Brown, H. W.:
J. Pediat. 45:419, 1954.

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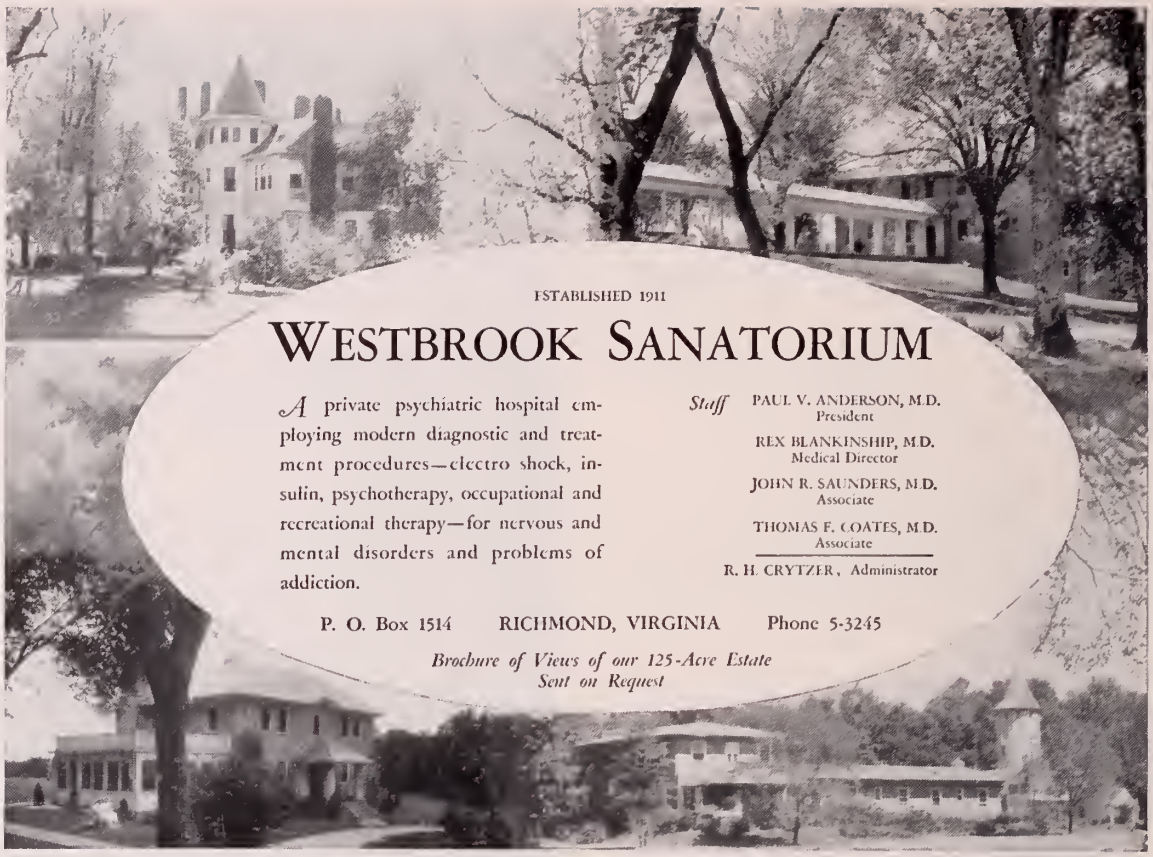
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(Continued from page 785)

CARROLL DUNHAM SMITH PHARMACAL CO. — 69

Our exhibit will feature Lipotriad (Smith), a new unusually potent lipotropic and oxytropic product, in both liquid and capsule form for the treatment of many conditions associated with faulty fat metabolism. Our representatives will also welcome the opportunity to discuss Calferbee, Quadra-Sed liquid, Neo-Sedaphen and other specialties.

BLAIR'S ASSOCIATE — 70

S. J. TUTAG & COMPANY — 71

AUDIO-DIGEST FOUNDATION — 72

Audio-Digest Foundation — a non-profit subsidiary of the California Medical Association — gives a busy physician an effortless tour through the best of current medical literature each week. This medical "newscast" — compiled and reviewed by a professional Board of Editors — may be heard in the physician's automobile, home, or office. The Foundation — whose profits are distributed among the nation's medical schools — also offers tape-recorded medical lectures by nationally-recognized authorities.

RITTER COMPANY, INC. — 73-74

M & R LABORATORIES — 75

Your SIMILAC representatives are happy to take part in this meeting. They are pleased to have the opportunity to discuss with you the role of SIMILAC in infant feeding. They have for you the latest Pediatric Research Conference Reports. Also available are current reprints of pediatric nutritional interest.

KELLOGG COMPANY — 76

ARLINGTON-FUNK LABS. DIV.,

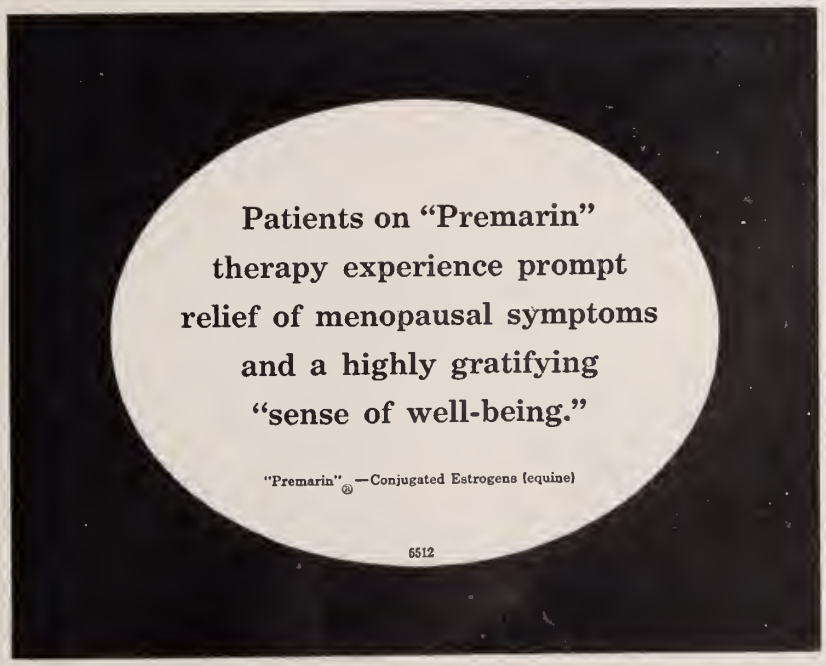
U. S. VITAMIN CORP. — 77

Our exhibit will feature C.V.P., a water-soluble, more active citrus flavonoid compound (vitamin P complex) potentiated by vitamin C. C.V.P. has been found to be highly effective clinically . . . proved by more than 2,000 cases thus far reported . . . in increasing capillary resistance and checking bleeding due to capillary fragility in hypertension, diabetes, purpura, uterine bleeding, post-surgical bleeding and other hemorrhagic conditions. It has also been found valuable in controlling symptoms and reducing fever in the common cold, influenza, pharyngitis, tonsillitis and certain respiratory infections.

Professional samples and literature on C.V.P. and other of our nutritional specialties will be distributed at our booth.

LEDERLE LABORATORIES DIVISION

AMERICAN CYANAMID CO. — 78





Whenever the diet is faulty, the appetite poor, or the loss of food is excessive

through vomiting or diarrhea—

Valentine's
MEAT EXTRACT

stimulates the appetite,

increases the flow of digestive juices,

provides: supplementary amounts of vitamins, minerals and soluble proteins,

extra-dietary vitamin B_{12},

protective quantities of potassium, in a palatable and readily assimilated form.

Supplied in bottles of 2 or 6 fluidounces.

***Dosage** is 1 teaspoonful two or three times daily; two or three times this amount for potassium therapy.*

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OBITUARIES

Charles Everett Hebard

Dr. Charles Everett Hebard of Tampa died on Nov. 10, 1954, at the home of his daughter, Mrs. Robert Newcomer, in Indianapolis, Ind. He was 64 years of age. Interment took place in Grand Rapids, Mich.

A native of Grand Rapids, Dr. Hebard in early boyhood moved with his family to the East Coast of Florida. He returned to Michigan for his medical training and was awarded his medical degree by the Detroit Medical College in 1918. He served in the Medical Corps of the United States Navy in World War I, seeing duty at Portsmouth, Va., and aboard the transport USS Antigone. Upon completing his military duty, he returned to his native state and entered the private practice of medicine in Grand Rapids.

In 1930, he came from Grand Rapids to Florida, locating in St. Petersburg, where he confined his practice to proctology. In 1942 he returned to the Navy with the rank of lieutenant commander and served with distinction in the Pacific area during World War II after being stationed for a time at the Jacksonville Naval Hospital. Upon his discharge he re-entered the private practice of medicine, practicing in Miami for two years. In 1948 he opened offices in Tampa, where he continued to practice until he became ill some months before his death. He served on the staffs of St. Joseph's Hospital and the Tampa Municipal Hospital. Locally, he was a member of the Palma Ceia Presbyterian Church, the Palma Ceia Golf and Country Club, the Elks Lodge and the Egypt Temple Shrine.

Dr. Hebard was a member of the Hillsborough County Medical Association, and since 1932 had held membership in the Florida Medical Association. He was also a member of the American Medical Association and the Southern Medical Association, and was a fellow of the American Society of Proctology.

Surviving are the widow, Mrs. Vera Hebard; one daughter, Mrs. Newcomer; one son, Charles E. Hebard Jr., of Detroit; one brother, Frank Hebard, of Grand Rapids; and four grandchildren.

Mitchell Macauley Andrews

Dr. Mitchell Macauley Andrews of Orlando died of a heart ailment on Oct. 20, 1954, in St. Louis, Mo., where he was attending a family reunion with seven of his brothers and two sisters. He was 71 years of age. Interment took place in Orlando.

Born March 8, 1883, in Beloit, Kan., Dr. Andrews was a graduate of the University of Nebraska. He received his medical training at Bellevue Hospital Medical College and New York University College of Medicine, and was awarded the degree of Doctor of Medicine in 1917. He then served an internship at Harlem Hospital in New York. During World War I he was a first lieutenant in the Army Medical Corps.

At the conclusion of his military service Dr. Andrews came to Florida and engaged in the general practice of medicine in Orlando with the late Dr. C. D. Christ. For many years he was associated with Dr. Christ, Dr. Frank D. Gray and Dr. Carolyn G. Williamson in the Christ Clinic on Lake Lucerne. Locally, he was a member of the staff of Orange Memorial Hospital. He was also medical director of the National Standard Insurance Company, of which he was one of the founders.

Dr. Andrews was a member of the Orange County Medical Society and for 34 years held membership in the Florida Medical Association. He was also a member of the American Medical Association.

He was married to the former Miss Anna Belle Allen of Longwood, who survives him. Also surviving are three sons, Ralph Macauley Andrews and John Lundy Andrews, both of Orlando, and Richard Roland Andrews, of Chicago; and one daughter, Mrs. Luana Williams, of Johnson City, N. Y. Other survivors are two sisters, Miss Nancy Mabel Andrews, of Orlando, and Miss Myrtle Emily Andrews, of Nashville, Tenn.; and seven brothers, Dr. Laurin Lundy Andrews, of Miami Springs, Dr. Vernon Lee Andrews, of Hollywood, Calif., Dr. Raleigh K. Andrews, of St. Louis, at whose home the reunion was being held, Austin Chandler Andrews and John Maitland Andrews, both of Kansas City, Mo., William Hiddleson Andrews and Marion Franklin Andrews.

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For the modification of measles and the prevention or attenuation of infectious hepatitis and poliomyelitis.

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FOOT-SO-PORT SHOES for Men and Women

There is o **FOOT-SO-PORT** ogency in all leoding tawns and cities. Refer to your Classified Directary

Foot-so-Port Shoe Company, Oconomowoc, Wis.

BOOKS RECEIVED

The Manual of Antibiotics 1954-1955. Edited by Henry Welch, Ph.D. Pp. 87. Price $2.50. New York, Medical Encyclopedia, Inc., 1954. Distributed by the American Pharmaceutical Association.

For the first time, there are gathered between the covers of one book a list of the preparations, therapeutic index, generic and trade names, and names and addresses of producers of all existing antibiotics and their preparations. The value of this information is obvious when one considers the tremendous increase in recent years of the number of trade names used for antibiotics. One single penicillin preparation, for example, has as many as 36 trade names. In fact, the number of trade names for the same drug is limited only by the number of manufacturers. Because of this multiplicity of trade names it has become practically impossible for the physician, pharmacist, and others engaged in the rise of these drugs to remember just what the composition of the product is from the trade name.

In this volume all of the presently commercially available antibiotic preparations are tabulated alphabetically by their generic terms. The trade names given to these products by each manufacturer are listed side by side with the generic equivalent. Under each of the generic terms the general indications for each drug preparation are shown. For ready reference these antibiotic preparations are alphabetically tabulated, both by trade and generic terms, in separate indices and an index of all manufacturers with their addresses is also included.

This manual is distributed exclusively by the American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington 7, D. C., as a service to the pharmaceutical and medical professions and to the drug industry.

Urology. Volumes I, II and III. Edited by Meredith Campbell, M.S., M.D., F.A.C.S. Pp. 2,356. Illus. 1,148 figs. Price $60.00 per set. Philadelphia, W. B. Saunders Company, 1954.

In the preface of this monumental work, the editor, Dr. Meredith Campbell, Emeritus Professor of Urology, New York University, relates that he declined a publisher's proposal that he write a one volume textbook on Urology because today's progress and developments in this branch of medicine and its collateral fields are so amazing, rapid, and variant that it is now beyond the scope of any one person to present all phases of this subject adequately. To achieve recognized authority for UROLOGY as distinguished from mere compilations gleaned from others, outstanding collaborators were enlisted. In this corps are those nationally or internationally renowned for their intensive investigative work and unusually wide experience in the sphere of their respective topics. Many of the contributions are classic monographs.

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1. Taggart, H. A.: Protein Metabolism in Relation to Nutritional Aspects of Medical Diseases, Pennsylvania M.J. *54*:339 (1951).
2. Marquardt, G. H.; Cummins, G. M., and Fisher, C. I.: Blood Protein Replenishment in Treatment of Nephritic Edema, Quart. Bull. Northwestern Univ. M. School *26*:140 (1952).
3. Kark, R. M.: Low Sodium and High Protein Diets in Laennec's Cirrhosis, M. Clin. North America *35*:73 (1951).
4. Kekwick, A.: Protein Deficiency in Surgical Patients, Ann. Roy. Coll. Surgeons England 7:390 (1950).
5. Stieglitz, E. J.: Nutrition Problems of Geriatric Medicine, Report of Council on Foods and Nutrition, J.A.M.A. *142*:1070 (Apr. 8) 1950.

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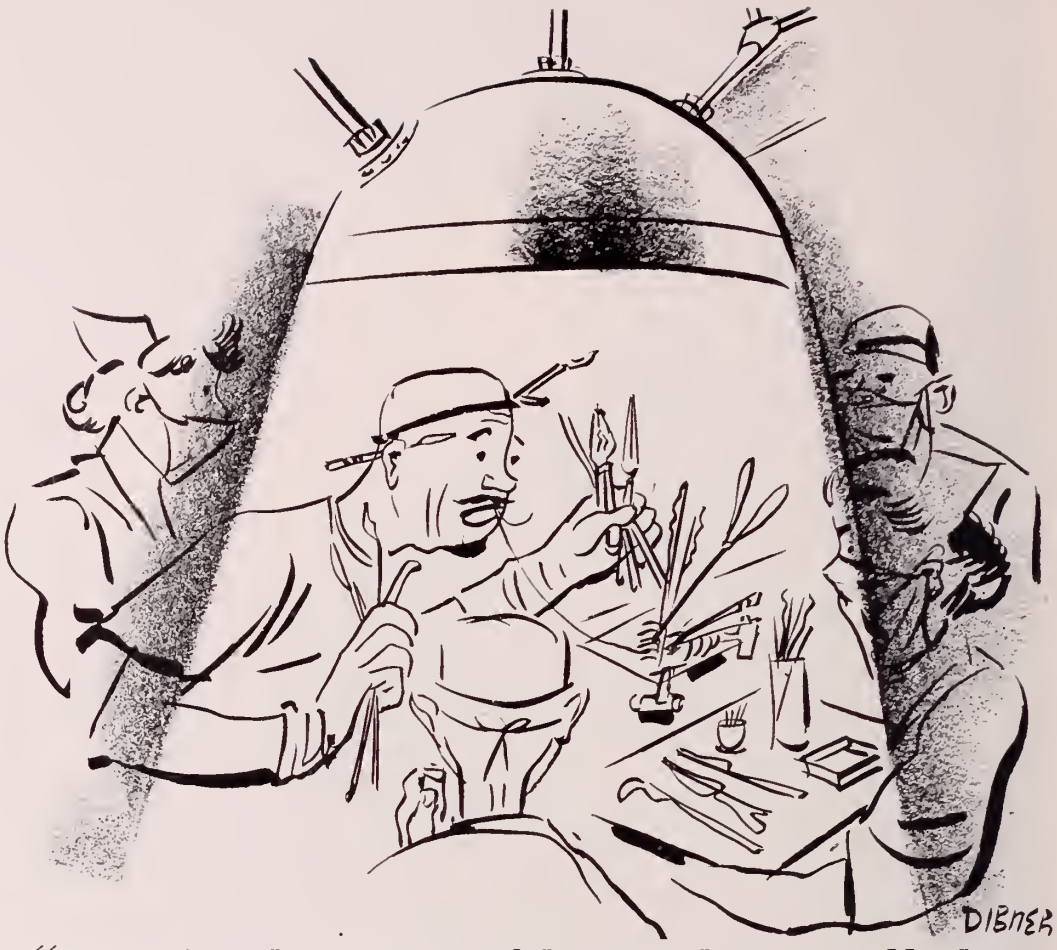
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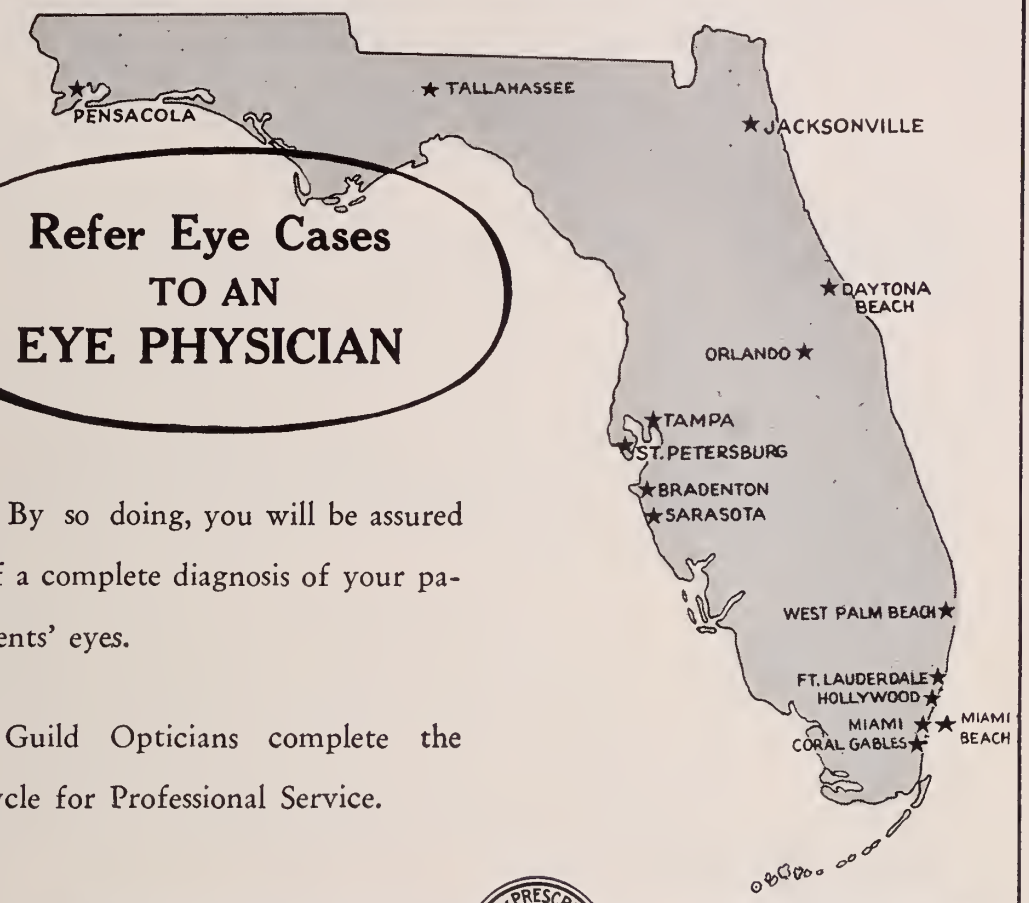
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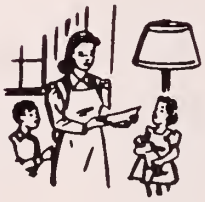
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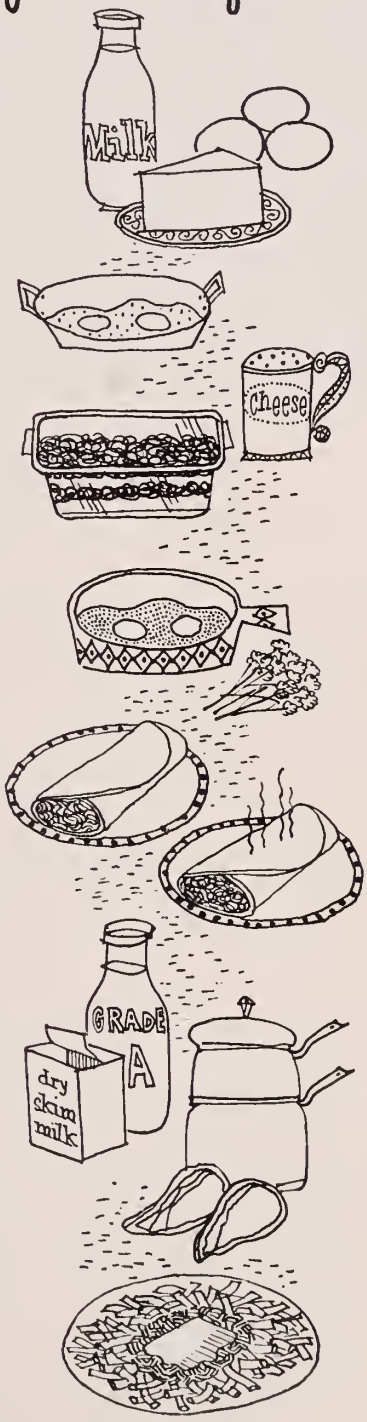
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Your patient may like his eggs poached in tomato juice. Then serve them in a soup bowl with a frill of chopped parsley on top.

In these, the trio plays accompaniment—

Ham 'n' egg rolls come hot or cold. For hot, roll a warm slice of ham around eggs that have been scrambled with a pinch of savory. For cold, roll ham around egg salad mixed with cottage cheese.

Oyster stew can be creamy without cream when the milk is bolstered with dry skim milk powder. A pinch of thyme and some chopped parsley add savor.

Broiled salmon or tuna-burgers nestle nicely in a nest of noodles. A slice of cheese on top adds color and broils to a bubbling brown.

These suggestions are only a few of the possible combinations of this versatile trio. And the adequate protein nutrition they make possible, plus a liberal intake of fluids, may help establish a regimen that will please you both.

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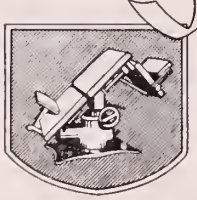
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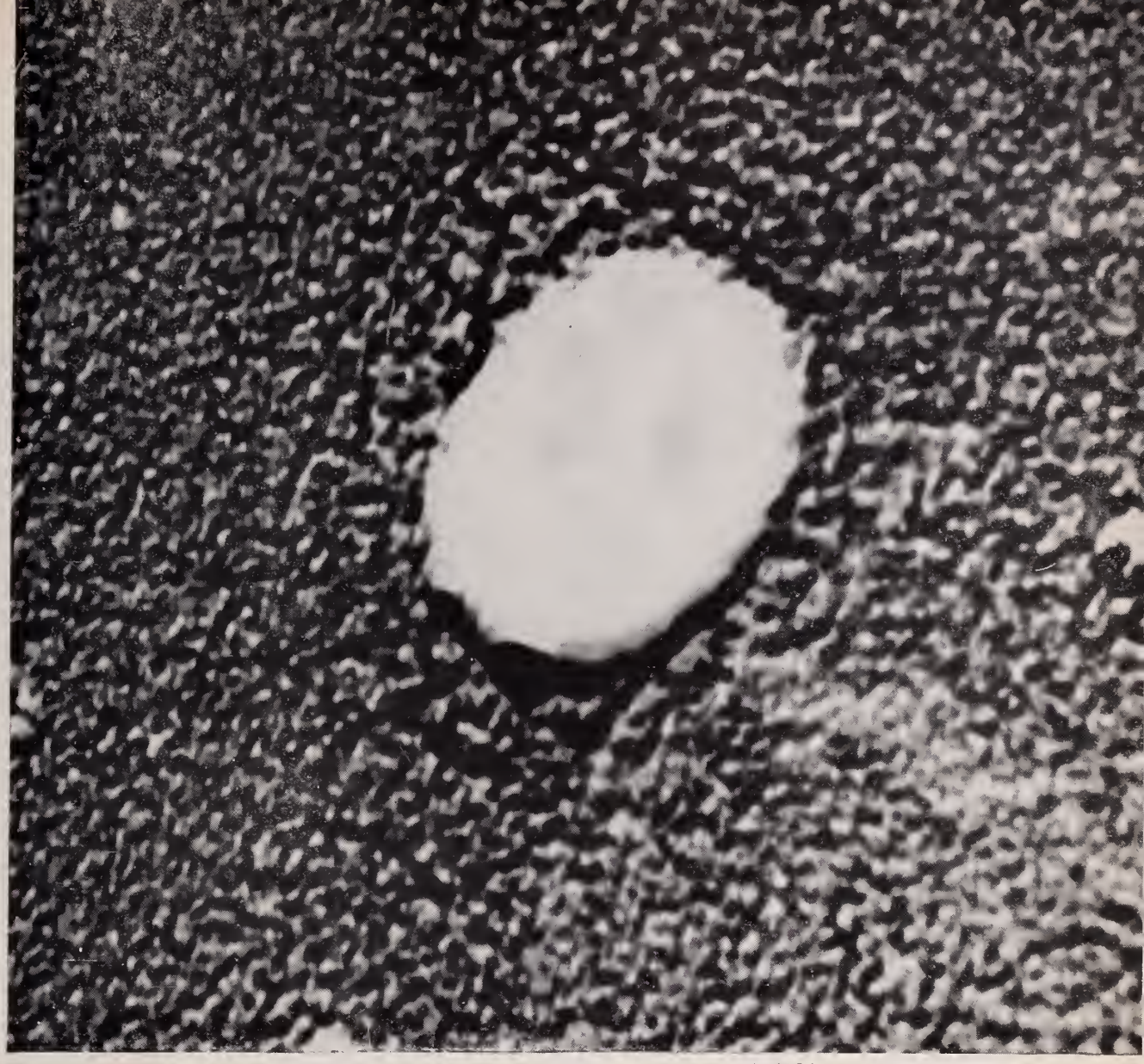
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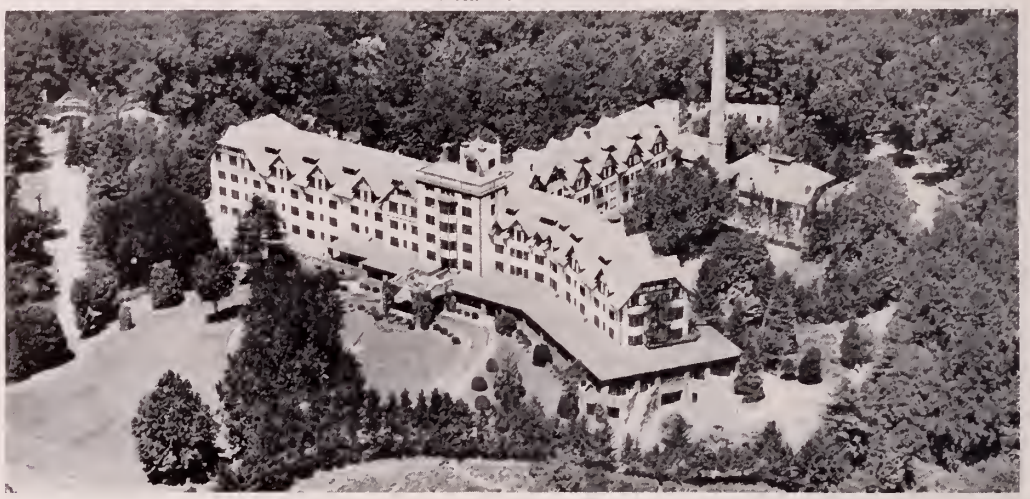
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rida Medical Association	Duncan T. McEwan, Orlando	Samuel M. Day, Jacksonville	St. Petersburg, Apr. 3-6, '55
rida Medical Districts	Francis H. Langley, St. Petersburg	Council Chairman	
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C-Southwest	Clyde O. Anderson, St. Petersburg	James R. Boulware Jr., Lakeland	Lakeland
D-Southeast	James R. Sory, West Palm Beach	Russell B. Carson, Ft. Lauderdale	Fort Lauderdale
rida Specialty Societies			
idemy of General Practice	Leonard L. Weil, Miami Beach	Leon S. Eisenman, Hialeah	St. Petersburg, Apr. 3, '55
ergy Society	Solomon D. Klotz, Orlando	Edwin P. Preston, Miami	" "
esthesiologists, Soc. of	R. Gaylord Lewis, West Palm Beach	Harry E. Bierley, West Palm Beach	" "
est Phys., Am. Coll., Fla. Chap.	DeWitt C. Daughtry, Miami	Jack Reiss, Coral Gables	" "
rm. and Syph., Assn. of	Hollis F. Garrard, Miami	Joseph A. J. Farrington, Jacksonville	" "
alth Officers' Society	Thomas E. Morgan, Jacksonville	Lorenzo L. Parks, Jacksonville	" Apr. 4, '55
lustrial and Railway Surgeons	Plumer J. Manson, Miami	John H. Mitchell, Jacksonville	" Apr. 5, '55
urology & Psychiatry	Sullivan G. Bedell, Jacksonville	Roger E. Phillips, Orlando	" Apr. 3, '55
and Gynec. Society	Harold G. Nix, Tampa	Reuben B. Chrisman Jr., Miami	" Apr. 5, '55
hthal. & Otol., Soc. of	G. Tayloe Gwathmey, Orlando	Carl S. McLemore, Orlando	" Apr. 3, '55
hopedic Society	John F. Lovejoy, Jacksonville	Newton C. McCollough, Orlando	" "
hologists, Society of	Millard B. White, Sarasota	James B. Leonard, Clearwater	" "
liatric Society	Lewis T. Corum, Tampa	Joel V. McCall Jr., Daytona Beach	" Apr. 5, '55
ctologic Society	Claude G. Mentzer, Miami	George Williams Jr., Miami	" Apr. 2, '55
diological Society	A. Judson Graves, Jacksonville	James T. Shelden, Lakeland	" Apr. 2-3, '55
geons, Am. Coll., Fla. Chapter	Frederick J. Waas, Jacksonville	C. Frank Chunn, Tampa	" Apr. 3, '55
ological Society	Linus W. Hewit, Tampa	Frank J. Pyle, Orlando	" "
rida—			
Basic Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, May 14, '55
Blood Banks, Association	John T. Stage, Jacksonville	John B. Ross, Jacksonville	St. Petersburg, 1955
Blue Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	
Blue Shield of Florida, Inc.	David R. Murphey Jr., Tampa	Jack O. W. Rash, Miami	St. Petersburg, Apr. 6, '55
Cancer Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	St. Petersburg, Apr. 3, '55
Clinical Diabetes Assn.	Sidney Davidson, Lake Worth	Edward R. Smith, Jacksonville	
Dental Society, State	Robt. Thoburn, D.D.S., Daytona Bch	J. E. Edwards, D.D.S., Coral Gables	Jacksonville, Apr. 23-25, '55
Heart Association	Alvin E. Murphy, Palm Beach	Daniel R. Usdin, Jacksonville	St. Petersburg, Apr. 2, '55
Hospital Association	Mr. J. F. Wymer Jr., W. Palm B.	Mrs. Mary Reeder, Miami	
Medical Examining Board	Frank D. Gray, Orlando	Homer L. Pearson Jr., Miami	
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, June 20-24, '55
Nurse Anesthetists, Fla. Assn.	Miss Dorothy Jackson, C. Gables	Mrs. Lulla F. Bryan, Miami	
Nurses Association, State	Martha Wolfe, R.N., Coral Gables	Agnes Anderson, R.N., Orlando	
Pharmaceutical Association, State	Mr. J. L. McDonald, St. Augustine	Mr. R. Q. Richards, Ft. Myers	Clearwater, May 23-25, '55
Public Health Association	Mr. J. A. Mulrennan, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Daytona Beach, '55
Trudeau Society	Lawrence C. Manni, Tallahassee	Simon D. Doff, Jacksonville	Miami, May 12-14, '55
Tuberculosis & Health Assn.	Judge Ernest E. Mason, Pensacola	Mrs. W. J. Norton, Sarasota	Miami, May 12-14, '55
Woman's Auxiliary	Mrs. Richard F. Stover, Miami	Mrs. S. J. Wilson, Ft. Lauderdale	St. Petersburg, Apr. 3, '55
erican Medical Association	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	Atlantic City, June 6-10, '55
A.M.A. Clinical Session	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	Boston, Nov. 29-Dec. 2, '55
uthern Medical Association	Robt. L. Sanders, Memphis, Tenn.	Mr. V. O. Foster, Birmingham	Houston, Nov. 14-17, '55
abama Medical Association	J. M. Donald, Birmingham	Douglas L. Cannon, Montgomery	Montgomery, Apr. 21-23, '55
orgia, Medical Assn. of	Peter B. Wright, Augusta	David Henry Poer, Atlanta	Augusta, May 1-4, '55
E. Hospital Conference	Mr. John W. Gill, Vicksburg, Miss.	Mr. Pat Groner, Pensacola	Atlanta, Apr. 20-22, '55
utheastern Allergy Assn.	W. L. Rucks, Memphis, Tenn.	Kath. B. MacInnis, Columbia, S. C.	Orlando, Mar. 25-26, '55
utheastern, Am. Urological Assn.	Sam L. Raines, Memphis, Tenn.	Robert F. Sharp, New Orleans	New Orleans Mar. 20-23, '55
utheastern Surgical Congress	J. Duffy Hancock, Louisville, Ky.	B. T. Beasley, Atlanta	Atlanta, Mar. 7-10, '55
lf Coast Clinical Society	Walter C. Payne Sr., Pensacola	Barkley Beidleman, Pensacola	Pensacola, Oct. 27-28, 1955



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County Medical Societies of Florida

SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Active Members
Alachua	Edwin H. Andrews, Gainesville	Henry S. Blank, Gainesville	2nd Tues.	51
**Bradford, Gilchrist, Union*				
Bay	William F. Humphreys Jr., Panama City	Roderick C. Webb, Panama City	1st Tues.	26
Brevard	Lee Rogers Jr., Cocoa	Charles E. Russell, Cocoa	2nd Tues.	27
Broward	Ernest E. Serrano, Hollywood	Alfred E. Cronkite, Fort Lauderdale	4th Tues.	113
Columbia	Robert B. Harkness, Lake City	Thomas H. Bates, Lake City	1st Mon.	11
**Baker, Hamilton*				
Dade	L. Washington Dowlen, Miami	Robert F. Dickey, Miami	1st Tues	672
De-Soto-Hardee-Highlands-Glades	Gordon H. McSwain, Arcadia	Harold S. Agnew, Arcadia	1st Tues.	27
Duval	Raymond H. King, Jacksonville	Eugene M. Frame, Jacksonville	1st Tues.	284
**Clay*				
Escambia	George W. Morse, Pensacola	Paul F. Baranco, Pensacola	2nd Tues.	104
**Santa Rosa*				
Franklin-Gulf	Warren T. Weathington, Apalachicola	Joseph P. Hendrix, Port St. Joe	Last Wed.	7
Hillsborough	Frank S. Adamo, Tampa	Julien C. Pate Jr., Tampa	1st Tues.	180
Indian River	Kip G. Kelso, Vero Beach	Vernon L. Fromang, Vero Beach	2nd Tues.	8
Jackson-Calhoun	Henry I. Langston, Marianna	Francis M. Watson, Marianna	Quarterly	16
Lake	Louis R. Bowen, Eustis	J. Basil Hall, Tavares	1st Wed.	27
**Sumter*				
Lee-Charlotte-Collier-Hendry	Baker Whisnant, Fort Myers	James L. Bradley, Fort Myers	3rd Mon.	37
Leon-Gadsden-Liberty-Wakulla-Jefferson	William L. Hunter, Monticello	Odis G. Kendrick Jr., Tallahassee	Quarterly	55
Madison	A. Franklin Harrison, Madison	Wallace E. Winter, Madison		5
Manatee	Marjorie L. Warner, Bradenton	Harvey C. Pauley Jr., Bradenton	2nd Tues.	24
Marion	William H. Turnley, Ocala	Bertrand F. Drake, Dunnellon	3rd Tues.	28
**Levy*				
Monroe	Ralph Herz, Key West	William R. Ploss, Key West	1st Thurs.	11
Nassau	David G. Humphreys, Fernandina Beach	John W. McClane, Fernandina Beach	Last Fri.	10
Orange	Don C. Robertson, Orlando	Walter A. Derrick, Orlando	3rd Wed.	175
**Osceola*				
Palm Beach	Edwin W. Brown, West Palm Beach	James R. Anderson, West Palm Beach	4th Mon.	136
Pasco-Hernando-Citrus	Harry G. Brownlee, Zephyrhills	W. Wardlaw Jones, Dade City	2nd Thurs.	15
Pinellas	Clyde O. Anderson, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	208
Polk	Samuel J. Clark, Lakeland	Marion W. Hester, Lakeland	2nd Wed.	85
Putnam	Grover C. Collins, Palatka	Alfred P. Peretti, Palatka	2nd Tues.	10
St. Johns	George C. Hopkins, St. Augustine	Reuben J. Plant Jr., St. Augustine	3rd Tues.	19
St. Lucie-Okeechobee-Martin	Henry E. Branca, Fort Pierce	Adrian M. Sample, Fort Pierce	3rd Thurs.	22
Sarasota	Melvin M. Simmons, Sarasota	Andrew J. Jesacher, Sarasota	2nd Tues.	51
Seminole	John M. Morgan, Sanford	Terry Bird, Sanford	2nd Tues.	20
Suwannee	William P. Blackmon, Mayo	Hiram B. Curry, Jasper	1st Sat.	9
Taylor	George H. Warren, Perry	Walter J. Baker, Foley	Last Fri.	4
**Dixie, Lafayette*				
Volusia	Robert L. Miller, Daytona Beach	Achille A. Monaco, Daytona Beach	2nd Tues.	78
**Flagler*				
Walton-Okaloosa	Richard H. Lee, Crestview	Frederic E. Caldwell, Fort Walton Beach	3rd Tues	18
Washington-Holmes	L. H. Paul, Bonifay	Bayllye W. Dalton, Chipley		4
			Total	2,577

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Clarence Bernstein and Solomon D. Klotz

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George A. Dame

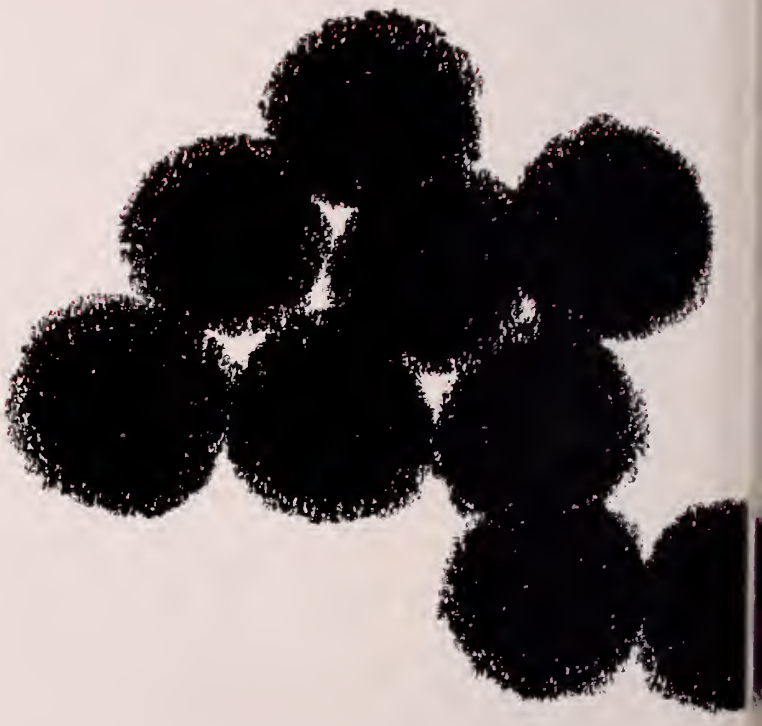
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James O. Bond and James C. Still

Tetanus In Dade County
C. J. Mathes

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to combat resistant bacteria.



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Volume XLI **APRIL, 1955** **No. 10**

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*Pratt, R., & Dufrenoy, J.: Texas Rep. Biol. & Med. *12*:145, 1954.

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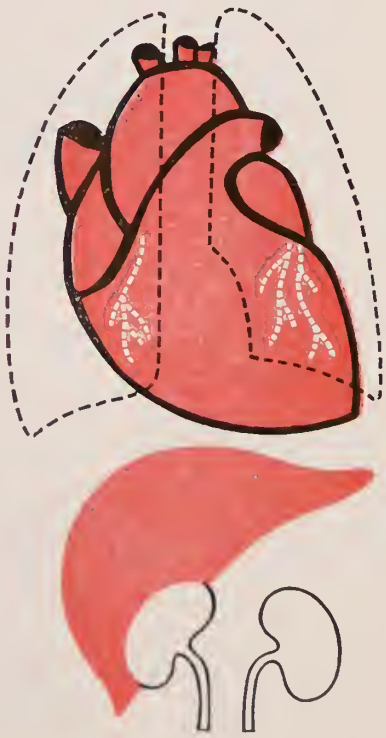
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REFERENCES: 1. Kroop, I. G., *N. Y. State J. Med.* **54**:2699, Oct. 1, 1954. 2. Heffer, E. T. *et al.*, *J. Pediatrics* **44**:630, June 1954. 3. Massell, B. F., *New England J. Med.* **251**:263, Aug. 12, 1954.

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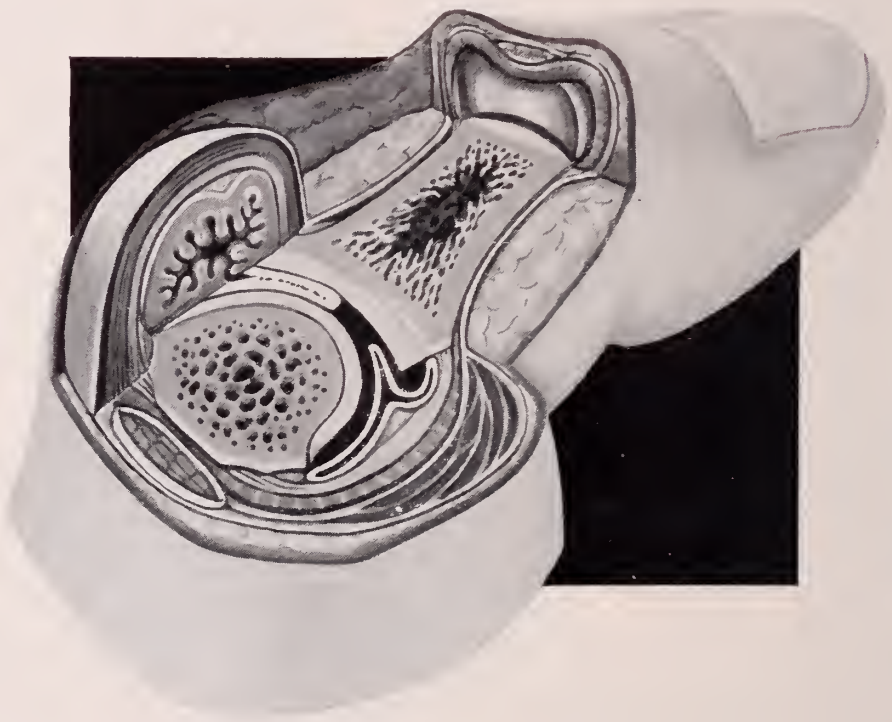
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*Bunim, J. J.: Research Activities in Rheumatic Diseases. Pub. Health Rep. 69:437, 1954.



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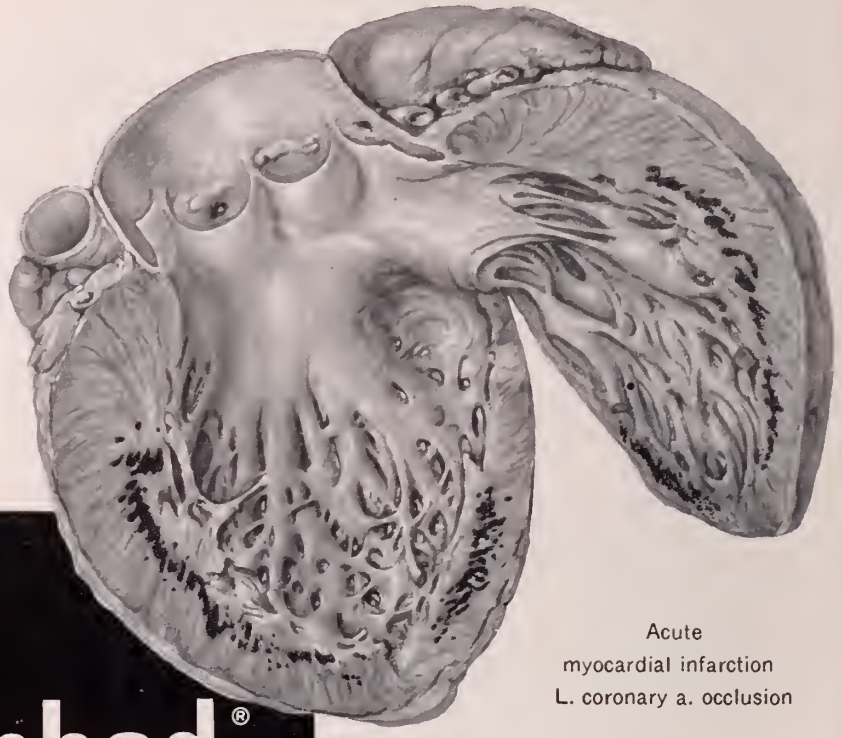
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1. Gazes, P. C., Goldberg, L. I., and Darby, T. D.: *Circulation*, 8: 883, Dec., 1953.

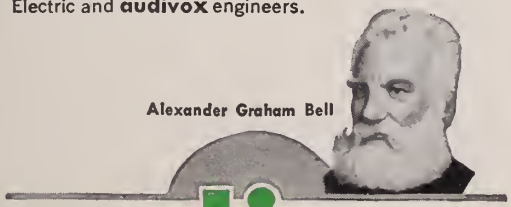
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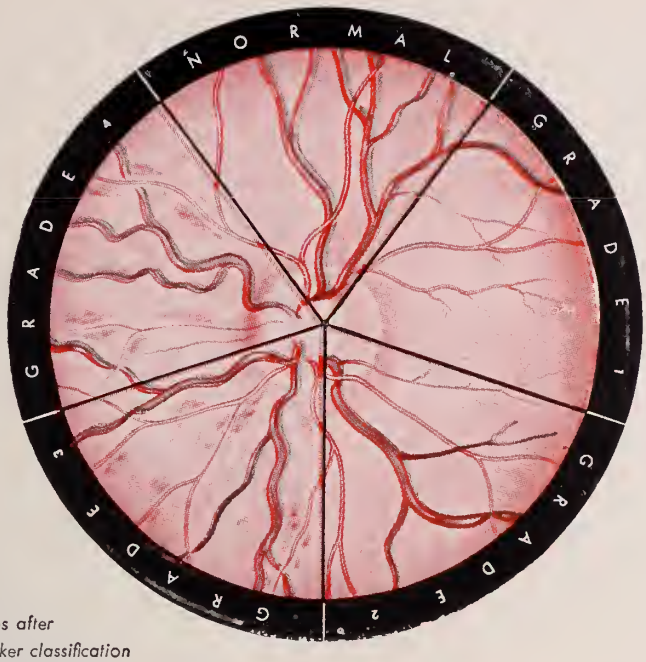
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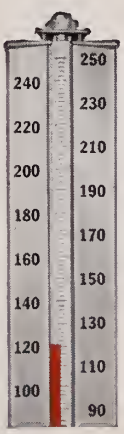
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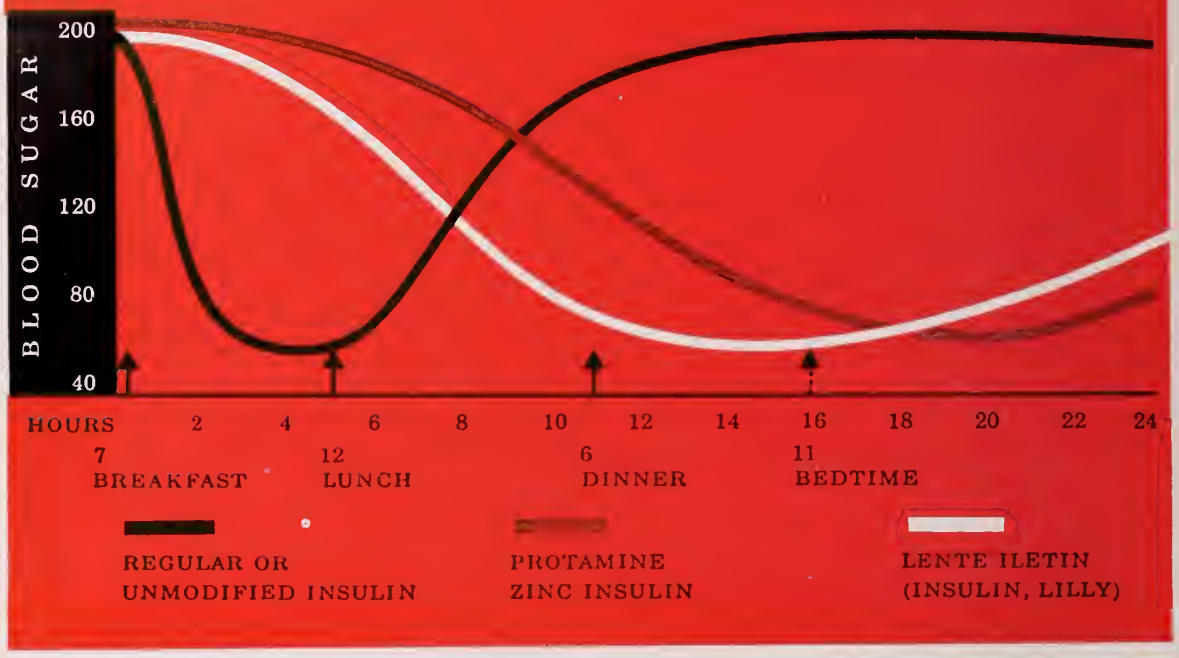
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Atopic Dermatitis

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AND
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ORLANDO

In an earlier paper on the intriguing subject of atopic dermatitis we suggested that "atopy," meaning "out of place" or "strange," and "dermatitis," which means an "inflammation of the dermis," when used together as "atopic dermatitis" might well signify "the strange disease of the skin." By common consent the term has been somewhat restricted in meaning by having been limited to inflammatory and irritative processes of the skin involving the upper corium. This is in contrast to lesions of the more superficial or epidermal layer, so-called "contact dermatitis," which, while related, is not classified in the category of atopic dermatitis or neurodermatitis. In atopic dermatitis one generally calls to mind the typical flexural distribution of the lesion with the varying amounts of thickening of the skin, thought of as a disease process developing in a hypersensitive person and due to sensitization by blood-borne agents. Synonyms for the condition have arisen as various observers from time to time have impressed their convictions on the medical profession in literature regarding this condition. We mention a few: neurodermite, neurodermatitis, generalized or disseminated neurodermatitis, hay fever eczema, pruritus with lichenification, et cetera (fig. 1). We personally have added still another name to this confusing and lengthy list, "allergic neurodermatitis," since in our experience the cases that could be classified as pure neurodermite or pure atopy were so few in number as to be rare clinical entities. Something of the nature of the problem is well brought out by Baer and Leider, quoted here at some length:

> The role and importance of allergic factors in this disease are often obscure. In many cases we have been unable to discover any evidence implicating allergic factors. The elucidation of the precise mechanism producing atopic dermatitis appears not at hand nor is the hope for new means of therapy any brighter.
>
> Attraction to the psychosomatic explanation for dermatoses of obscure etiology has started all over again. . . . In this field there is a tendency to self-deluding mysticism and escapist obscurantism. What is the general psychosomatic content of a four-month-old infant with atopic dermatitis? What is that of a six-year-old, an adolescent or young adult with this condition, that distinguishes them from ordinary mortals? How does psychosomatic theory explain the spontaneous abatement of the disease in the large majority of cases in early middle life? Do maturity and insight come naturally at twenty and after? In a large clinical material, ordinary observation of personality revealed no significant differences to these authors between persons afflicted with cutaneous atopy and those suffering from any other dermatosis. If anything, the former bear their disabilities with more creditable fortitude than the rest of us.
>
> Hill has written two papers which discuss the contradictions between skin test results and the clinical and therapeutic effects of exposure or avoidance of skin-test-positive and skin-test-negative agents. The dissociation between positive test results and the inefficacy of procedures of avoidance of allergens that are incriminated by test is as distressing to physician as to patient.
>
> We have gained the impression that from the view point of the allergist the reasons for the intractable nature of atopic dermatitis are as follows:
>
> 1. The number of sensitizations (the number of offending allergens) in some cases may be large and much larger than is indicated by testing, no matter how extensive the testing.
>
> 2. The duration of each sensitization may be exceedingly variable, or the level of each sensitivity may be constantly rising and falling. Also, the pattern of sensitization, i.e. the kind of allergens operative at any one time, fluctuates. For example, at one time, through frequency of exposure, silk

Read before the Southeastern Allergy Association, Annual Meeting, Atlanta, Ga., March 27, 1954.

gave positive skin tests very commonly, only now to have almost disappeared to the point of negligibility.

3. Complete avoidance of all allergens offensive at any given moment is well nigh impossible.

These as well as other ponderables and imponderables have clouded and continue to obscure our thinking and conclusions on this whole perplexing problem. The availability of cortisone and ACTH have given us powerful, and at times dangerous, therapeutic tools. Physiology-wise they have shed a little more light on the mechanisms involved, but they have not solved this clinical puzzle. We must, as hitherto, look at the skin and at the patient.

Fig. 1. — Atopic Dermatitis or Neurodermatitis

1. Circumscribed type
   (Neurodermatitis circumscripta chronica, lichen simplex chronicus of Vidal)
2. Disseminated type or atopic dermatitis (Sulzberger) or generalized neurodermite of Brocq, or eczema-asthma-hayfever complex of Stokes, or prurigo, diathesique of Besnier, flexural eczema, or allergic neurodermatitis
3. Atopic infantile eczema
4. Moist forms:
   Dyshidrotic eczema, hands and feet
   Nummular eczema?

The skin mirrors the inward reactions of the individual in various ways: vasoconstriction, sweating, and pallor from fright; blushing from embarrassment; and erythema from sunburn, or from an injection of histamine. Indeed, an allergic response may be "taken over" and appropriated by a nerve pathway as in a conditioned reflex. It is this transfer or conversion phenomenon that places any truly scientific proof for many of our conclusions in serious jeopardy. The interrelation of allergic and anxiety-tension states has been so generally recognized that it is often impossible to quantitate the two in any given instance. The seasoned practitioner, however, attacks both salients if he wishes to bring about promptly the happiest results for his patients. He may require neither exhaustive skin testing nor extreme elimination diets, nor will he go beyond his depth in probing the psyche in order to prop up a sagging ego. In this latter regard common human sympathy and a nonstupefying barbiturate may be all that are required.

Allergy-wise the history is most important and may give us our most significant leads: location of lesion; season of year; other allergies in person or family; precipitating factors such as new foods, or new situations (environmental or otherwise).

The further addition of an allergy burden to an already overloaded person may prove to be the "straw that breaks the back" of a chronically thin adjustment, precipitating the highly stressful situation that has thus far been avoided. When the stress can no longer be met, or neutralized, its manifestations become evident in the shock organ, in this instance the skin.

In children or young adults the lesion may start with itching, and progress through erythema, vesiculation, oozing, crusting, excoriation, and lichenification (fig. 2). To this group the typical flexural distribution at the antecubital or popliteal spaces is practically a sentinel sign. The older group more often presents the signal patch behind the ear, or at the hair line, or the back or side of the neck, or on the dorsum of the hand. Tiny vesicles appearing along the sides of the fingers frequently herald the more outspoken attacks and must be differentiated from dyshidrotic or trichophytid lesions. This vesicular type of onset is seen more commonly when the tensional factors predominate, and specific clues are less readily obtained than in the other adult group just described.

Fig. 2. — Contributing Pathogenic Factors in Atopic Dermatitis

1. Atopic sensitivity
2. Other skin sensitivity
   (1) Epidermal sensitivity
   (2) Infectious sensitization
3. Constitution
   (1) Heredity
   (2) Neurovascular instability
   (3) Personality traits
4. Hormonal factors
   (1) Hypothyroidism
   (2) Estrogen imbalance
   (3) Hormonal deficiency in the male
5. Environmental factors
   (1) Psychologic conflicts and emotional upsets
   (2) Situations of stress and strain
6. Complications and aggravating factors
   (1) Secondary infection
   (2) Contact dermatitis
   (3) External irritation: mechanical, chemical, actinic, heat, cold, humidity

From Stephan Epstein, M.D.

It is patients with the diffuse eczematous type of lesion that we see in Florida with ever increasing frequency, in whom the relationship of the onset to food intake or seasonal incidence assists us in the diagnosis. Typical of this variety of patient is the tourist who really tries to "drink all the orange juice he can for a quarter." While occasionally a classical urticaria develops, more often we see the garden variety atopic dermatitis. Similarly, during the oak pollen season

from late January to early March we encounter dermatoses initiated by exposure to these pollens. It is true that on careful search "other factors" can be found, particularly the stressful situations that so frequently precede or coexist with the dermatoses. In the case of the pollens, we are apt to see the so-called "contact type" atopic dermatitis, which represents in all probability a true extension of the pathologic condition to the epidermal cells (fig. 3).

Fig. 3. — Allergic Traits: Neuroemotional Instability

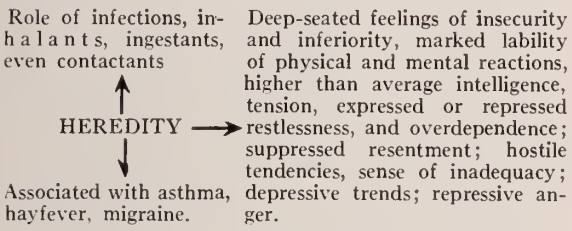


Fig. 4. — Essentials of Treatment

1. Basic exclusion diet
2. Avoidance of suspected inhalants, dust and feathers
3. Sedation
4. Avoidance of irritants, soap and water
5. Calcium gluconate by vein
6. Crude liver (occasionally Kutapressin)
7. Antihistamines: Chlor-Trimeton and others
8. Local soaks and ointments
9. Hyposensitization therapy; histamine
10. Hormones: ACTH, androgens, estrogens
11. Fever therapy, vaccines and Piromen
12. Psychotherapy

Our skin tests are generally limited to the pollens, molds, common skin fungi, milk, egg, citrus, cocoa, tomato, cottonseed, feathers, dust, bacterial vaccine, staphylococcus toxoid, and one or two other foods included as much for a control as for any other reason. These, with the history, give us enough information for a start. If tests for inhalants and fungi give negative results, the patient receives the following (fig. 4):

A. Basic Exclusion Diet: Avoid milk and milk products, egg, citrus, chocolate, tomato, nuts and shortening.
Caution List: Pork, seafood, corn products, chicken, strawberry, melons, cucumber, garlic, peppers.

B. Avoid dust and feathers.

C. Sedation: Usually phenobarbital or Butisol sodium in suitable dosage; occasionally bromide or chloral hydrate.

D. Avoidance of soap and water on involved areas. Medical detergent soaps such as Lowila or Acidolate suggested. Use of rubber gloves and cotton liners recommended.

E. Calcium gluconate intravenously and crude liver intramuscularly twice weekly. Occasionally Chlor-Trimeton is added to the intravenous solution. Rarely dilute nonspecific vaccine is given by vein (Results with Piromen are no better). In a few instances we have used Kutapressin in lieu of liver, when the latter was not tolerated.

F. Chlor-Trimeton, 8 mg. every six to eight hours by mouth (or other antihistamine in suitable dose), to reduce itching and local heat.

G. Local Soaks and Ointments: Our all purpose ointment has been Aquaphor with equal parts of water, and more recently Eucerin, ready-prepared. We also have found Perazil and Neo-Antergan creme useful when more than a protective effect was desired. Contrary to frequent reports these ointments are useful even in weeping eczemas, if not too wet. If so, the drying ointments or soaks, Aveeno, Burow's solution or potassium permanganate, have been helpful. Amertan jelly, a tannic acid-gum tragacanth preparation, often serves most usefully if the inelegant immediate cosmetic effect is not too distasteful. Vioform and tar ointments have been used but seldom.

H. Hyposensitization to specific materials is used when skin tests give indication. Dust, pollens, or molds, toxoids, or bacteria when employed are generally used in greatly diluted strength; 1:100,000 and 1:1,000,000 are not unusual solutions. Further, we have found histamine in aqueous or gel solution a most helpful nonspecific adjunct in therapy. Lately Histapon has become available, and under certain conditions we use this, particularly in combination with ACTH.

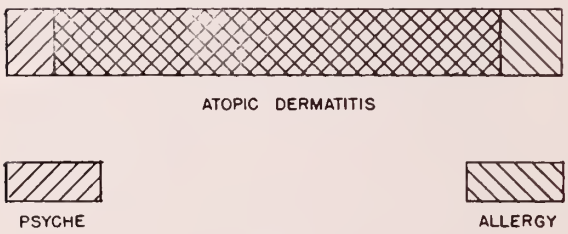
I. The adrenocorticotrophic hormone has been of inestimable value (a) in the more acute fulminant forms; (b) in shortening what might prove to be a long and arduous course of treatment, and (c) in those rare instances in which every form of therapy is met by some untoward reaction. We have found the slow intravenous drip, lasting six to eight hours using a 7.5 to 10 unit dose in 24 hours, the most suitable means of administration. Not infrequently we combine intramuscular or intravenous histamine therapy with this. We have

used more ACTH gel lately, employing a larger dose because of its prolonged absorption. We have also utilized cortisone E and F in cautious dosage as well as the ointments topically. With proper safeguards these are most gratifying, but offer no "cure."

J. Fever Therapy, Vaccines and Piromen: These all have or have had their places, but since the availability of ACTH, we have used them and other nonspecific methods less and less.

K. Psychiatry: Rarely employed, but indicated in selected cases. More often all that is required is a listening ear and sympathetic counsel (fig. 5).

Fig. 5. — Schematic Representation



Results

By and large, clinical benefit has been most gratifying. This is particularly so since in our area a goodly proportion of the patients with dermatologic problems finally gravitate to the allergists. In fact, when one of these patients reaches us, he is ready to "try anything" — or nothing. A nationwide poll of allergists was recently conducted to learn in what percentage of cases they found specific offenders in both contact and atopic dermatitis. While reports naturally varied, there was general agreement that in contact dermatitis the offender could be found in 75 to 85 per cent of cases, whereas in atopic dermatitis the "batting average" was about 45 to 50 per cent. Our experience parallels this observation.

By no means would we want to leave the impression that these figures have anything to do with clinical results. They do mean, however, that in atopic dermatitis one must use polyphasic, polypragmatic therapy, as it has been called, to achieve the most satisfactory cure, using the term in this instance to mean the restoration of the skin to a normal or near normal state. Even so, one must anticipate recurrences, as well as unusual new situations productive of this clinical entity. The broad outlines presented will adequately cover most cases. In our opinion one cannot point to any single modality of treatment as accounting for a clinical result when the broad program of attack we recommend is employed. It does, however, offer effective and almost certain help to the patient, which after all continues to be the fundamental aim of sound clinical practice.

Summary

Certain aspects of the pathogenesis and clinical features of atopic dermatitis are presented.

The dual role of allergic sensitization and neurogenic factors in the etiology is discussed.

Detectional methods of the allergist are frequently necessary to reach specific causative agents, but increasing attention to the host-reactor has revealed valuable information helpful to patient and physician alike.

Treatment at times must be local as well as general, both specific and nonspecific, if clinical benefits are to be achieved promptly. These are briefly outlined and their limitations suggested.

The increasing incidence of atopic dermatitis lends timely interest to a review of current information on this perplexing clinical problem.

References

Baer, R. L., and Leider, M.: Progress in Allergy; Dermatologic Allergy, Ann. Allergy 5:578-593 (Nov.-Dec.) 1947.

Becker, S. W., and Obermeyer, M. E.: Modern Dermatology and Syphilology, ed. 2, Philadelpbia, J. B. Lippincott, 1947.

Bernstein, C.: Allergic Neurodermatitis, Urol. & Cutan. Rev. 49:684-687 (Nov.) 1945.

Bernstein, C.: Atopic Neurodermatitis, read before the Soutbern Medical Association, Miami, November 1952.

Epstein, S.: Allergic Dermatitis; Present-Day Concepts and Management, Quart. Rev. Allergy 5:244-275 (Sept.) 1951.

Rothman, S., and Walker, S. A.: Problem of Emotional Factors in Allergies, Int. Arch. All. & Appl. Immunol. 1:306, 1951.

Sulzberger, M., and Baer, R. L., editors: Yearbook of Dermatology, 1950, Chicago, The Year Book Publishers, Inc., 1951.

Sulzberger, M. B.; Witten, V. H., and Yaffe, S. N.: Cortisone Acetate Administered Orally in Dermatologic Therapy, A. M. A. Arch. Dermat. & Syph. 64:573-579 (Nov.) 1951.

Urbach, E., and Gottlieb, P. M.: Allergy, ed. 2, New York, Grune and Stratton, Inc., 1946.

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Proceedings of Eighty-First Annual Meeting Scheduled for Publication in the June Issue

County Health Units in Florida

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JACKSONVILLE

This paper will discuss briefly county health units in Florida, established and maintained under the provisions of the "Enabling Act of 1931" (Chapter 14,906, No. 268, General Laws of 1931). By usage and for convenience a unit is now described as that area under the administration of one director, and composed of one, two or three county health departments, based on population and area, and convenience of administration.

History

In the beginning all public health programs were operated by and from the central office. All personnel were employed by and were directed from the headquarters in Jacksonville. There was no local participation. Several cities had their own health departments.

The second phase of public health in Florida was a slow development of finances and programs. Eventually a number of districts were set up. In the latter part of this phase there were eight districts, the larger ones having a health officer, a nurse, a sanitarian and a clerk; several only had a health officer. Still all employment, direction and financing were from the central office. Programs were limited, and services were thinly spread. There was no organized local participation.

By 1921 a great deal of thought had been given to the idea of setting up local units in which there would be local participation in finances and responsibilities; programs would be localized and expanded. It was then determined that a bureau should be set up in the State Board of Health to make a careful study of the whole matter, to have charge of formulating a plan for setting up local units, and to have direction, under the State Health Officer, over operation, financing, staffing, and supervision of programs in the units.

At a meeting of the State Board of Health held October 11, 1921, the Bureau of Venereal Diseases was changed by title into the Bureau of Communicable Diseases and Health Units.

Following a conference between Colonel Raymond C. Turck, State Health Officer, and Dr. John A. Ferrell, Regional Director of the International Health Board of the Rockefeller Foundation, I was detailed by Dr. Turck to work in cooperation with Dr. John Lee Hydrick of the International Health Board to make a study of local health units in several Southern states and to work out a detailed plan. This plan was submitted and adopted, and is given on pages 40 to 45 of the Annual Report for 1921.

Considerable effort, time and some money were spent in attempting to set up county health units in Palm Beach and Polk counties. These efforts were not successful, and an explanation is furnished in this quotation from the 1921 report: "(Note: Plans for the establishment of Health Units have been temporarily abandoned on account of lack of funds)." The state legislature of 1921 reduced the State Board of Health appropriation from its previous one-half mill to a new low of one-quarter mill. The administration had been elected on a promise to reduce the state millage, and when the legislature had finished its labors, it was found that for all state activities for which taxes were levied there had been a one-quarter mill reduction, and all of this had been taken from the State Board of Health.

No reports were made then for 10 years until Dr. Henry Hanson was appointed State Health Officer and gathered up the fragments for a report which he made Jan. 1, 1933. In a report submitted at this time by Dr. F. A. Brink, Director of the Bureau of Communicable Diseases (note the change in title), he made this reference: "With the aid of the personnel of the United States Public Health Service and a substantial cash contribution, three county units have been organized:

"The Taylor County Health Unit began to function September 1, 1930. The Leon County Unit began on January 1, 1931. The Escambia County Health Unit began March 1, 1932. After June 1, 1931, the State Board of Health contributed a substantial amount to the budget of each unit, and the Public Health Service continued its

Read before the Florida Health Officers' Society, Ninth Annual Meeting, Hollywood, April 25, 1954.

support with slightly diminished allotments. These units render locally the services that would otherwise come from the State, and they render it more completely because the personnel is more nearly adequate for the area and population served. The promotion, direction and supervision of these units is now a duty of the director of this bureau."

On Jan. 1, 1935 the Bureau of County Health Work was set up with Dr. James T. Googe as director. Dr. Googe was loaned to the State Board of Health for this purpose by the United States Public Health Service. He was detached from the United States Public Health Service Feb. 1, 1936, and remained as director until Oct. 8, 1936. Dr. Googe worked earnestly and intelligently for the promotion of public health on the local level. He has fortunately been followed by several other directors equally devoted and able. It is to be noted that along the way the title of the bureau was changed to the Bureau of Local Health Service. As of this date all counties, with the exception of St. Johns, have accredited county health departments. There is a great deal of interest in St. Johns County, and it is believed that an accredited department will be set up there in the near future.

Statistics

At the close of the year 1945 there were 37 accredited county health departments, administered as 26 county health units. These county health departments covered 55.2 per cent of the 67 counties of the state. They served a population of 1,819,472, or 80.8 per cent of the state's total population of 2,249,649 according to the 1945 State Census. There were 497 persons employed in the county health departments.

As of Dec. 31, 1953 there were 66 accredited county health departments, administered as 37 county health units, all counties of the state except St. Johns having come into the fold. According to federal estimates the population of the state was then 3,171,000. The population served was 2,925,597, or 92.26 per cent of the whole. At that time there were 912 persons employed in the county health departments, as well as 22 on loan by the United States Public Health Service and by the State Board of Health.

At the end of 1945 the total amount budgeted in county health departments was $1,322,795, or 72.7 cents per capita of population served. This amount was built up as follows:

County contributions per capita	45.1 cents
State contribution per capita	13.5 cents
Federal contribution per capita	14.1 cents
Total per capita	72.7 cents

As of Dec. 31, 1953 the total for the budgets of the county health departments allocated on the formula was $3,574,420, or $1.405 per capita of population served. This total was contributed as follows:

County contributions per capita	93.4 cents
State contribution per capita	42.8 cents
Federal contribution per capita	4.3 cents
Total per capita	140.5 cents

Needs

In discussing needs it is necessary to give consideration to the various causes of illness and death, and consequent unhappiness and financial loss; the scope of the problem; the means of prevention and cure; the relationship of curative medicine and preventive medicine; and their close relationship. Due thought should be given to the amazing advancement of physicians in knowledge and skill, and to the fact that not only are they actually sacrificing their lives to the cure of disease, but are increasingly devoting a considerable part of their time and effort toward the prevention of disease. So many who have devoted themselves up to the age of 30 in preparation are dead before 60. Due credit should also be given the related disciplines of dentistry, pharmacy and nursing, and ancillary hospitals and laboratories.

Likewise, due thought should be given to that other branch of medicine called preventive. The operation of this branch, per se, is supported by taxation and is a necessary function of government, federal, state, county and city. All governments have accepted the responsibility for good health, along with good education, good roads and good national defense. Sometimes it is not fully accepted that good health should be a primary consideration. It should be. Without adequately supported preventive medicine and public health there is too much waste of natural resources, the greatest item of which is human resources, the people.

Some of our ancient evils are being gradually brought under control. In a period of nine years tuberculosis death rates in Florida have shown a decrease of 68 per centum; syphilis, 64 per centum; typhoid, 83 per centum, and typhus fever, 92 per centum. But new killers are coming rapidly to the front; heart disease shows an increase of

41 per centum; and cancer, 46 per centum. Polio is still frightful; hookworm disease with its insidious evils is still a disgrace to a modern, civilized, and progressive state. Mental diseases are increasing and constitute one of our greatest handicaps. The cost in money, unhappiness and death is truly great. While the incidence of many diseases has been reduced, the fight against them cannot let up; they would flare up again.

It is generally accepted by public health specialists in this state that to carry out the ideal programs of public health and preventive medicine in Florida, the following ratio of certain categories of personnel is needed to serve adequately certain numbers of population:

Health Officers:	40,000 population, or a total of 73
Nurses:	5,000 population, or a total of 585
Sanitarians:	8,000 population, or a total of 365
Clerks:	12,000 population, or a total of 243
Clinic Aides:	15,000 population, or a total of 195
Dentists:	50,000 population, or a total of 58
Nutritionists:	50,000 population, or a total of 58
Health Educators:	50,000 population, or a total of 58
Psychologists:	50,000 population, or a total of 58
Engineers:	50,000 population, or a total of 58

This ratio would require new and additional personnel as follows: Health Officers 26; Nurses 262; Sanitarians 189; Clerks 69; Clinic Aides 164, Dentists 52; Nutritionists 58; Health Educators 55; Psychologists 54; Engineers 52. To employ this adequate total of personnel, to pay increased travel, and to supply equipment and supplies referred to as "Other Expenses" would require a total budget of $7,417,820 as compared to our present total budget of $3,574,420.

In view of the rapid decrease in federal funds and with thought to the available tax resources as between counties and states, it would require, in order to obtain funds to carry out the plan discussed in the preceding paragraph, that counties appropriate approximately $1.70 per capita, or $4,973,515, and that the state appropriate 85 cents per capita or $2,486,757. These figures should be increased each biennium on the basis of federal estimates of population increases. This schedule, while ideal, is not now practical, nor is it attainable.

To set up a realistic, practical and obtainable statement of financial needs, it is reasonable to state that counties should contribute two thirds and the state should contribute one third of operating funds. The federal grants-in-aid are becoming negligible and should not enter into our calculations. It is then reasonable to expect that the counties, including St. Johns, should contribute 92 cents per capita per annum for a total population of 3,130,000 based on estimates by the Federal Bureau of the Census, or a total of $2,900,000; and that the state should contribute 46 cents per capita, or a total of $1,450,000 per annum. This plan then would give the county health departments a total annual budget of $4,350,000, or approximately $1.39 per capita. This budget would permit the county health departments to render a fair program of public health and preventive medicine by providing a slight increase in personnel, a slight increase in quality of personnel, a slight increase in travel and other necessary expenses; and a slight increase in training of some of the major personnel. Only a person who has given close study to the over-all problem can realize fully the necessity for this slight expansion.

In a discussion of the financial needs of county health departments careful thought also should be given to the financial needs of the central office. All of the services performed by personnel of the central office are rendered either directly or indirectly to the county health departments. All funds appropriated for the maintenance of the central bureaus and divisions are actually in the long run necessary for the proper servicing of county health departments. For the past few years the State Health Department has been badly crippled for lack of sufficient funds. This handicap in turn has resulted in detriment to the local health departments.

At a proper time the whole field of needs of the bureaus and divisions and the county health departments will be carefully surveyed in comparison with the amount of funds that may reasonably be expected to be appropriated by the legislature. A reasonable and equitable schedule of appropriations then will be worked out and submitted to the legislature by the State Health Officer.

Box 210.

Infectious Hepatitis: Report of an Outbreak In School Children In A Small Community

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ARCADIA
AND
JAMES C. STILL**
JACKSONVILLE

During the period from May 1952 to March 1953 there occurred an outbreak of 29 cases of infectious hepatitis in children in Avon Park, a small town of 6,131 population in the south central portion of the state. Although the number of cases was relatively small and the disease in each case followed the usual mild course in children, since such occurrences are usually overlooked, it is thought that the reporting of this outbreak may be of interest to doctors in similar communities and to public health personnel interested in the method of spread of this disease.

Review of the Literature on Epidemiology of Infectious Hepatitis

The accumulation of experimental evidence on the factors involved in the spread of infectious hepatitis has been limited by the fact that man is the only satisfactory experimental animal. Numerous attempts to produce infectious hepatitis by giving the virus to laboratory animals including rodents, monkeys, pigs, birds, and even chimpanzees have either failed, or not been confirmed.[1-4] Puppies and mice have a viral hepatitis, but there is no known relationship with the human disease. All pertinent data have been acquired in experiments with human volunteers. There is good evidence from these to show that the virus is present in the blood and feces of the infected person in the late preicteric and the acute icteric phase of the disease and the administration of serum or stool obtained from patients at these times will produce the disease in human volunteers.[5] It has been further shown experimentally that the virus excreted in the stools may be transmitted via contaminated water to other human beings.[6] It is well known that the virus present in the blood may be transmitted to susceptible persons via infusions of blood and blood products, and by contaminated syringes and needles.[7] Havens[5] has shown that as little as .01 ml. of serum taken from a patient during the acute stage will produce the disease upon inoculation into volunteers. It is as yet not definitely known when the virus appears in the blood and feces and how long it remains there, but it is presumed to remain there at least a month and probably longer. Stokes[8] was able to demonstrate the presence of hepatitis A virus in stools of 2 children who showed evidence of hepatitis without jaundice five and 15 months prior respectively.

Evidence on the occurrence of the virus elsewhere in the body is less conclusive. The disease was reportedly transmitted to human volunteers by nasopharyngeal secretions by MacCallum and Bradley.[9] Neefe and Stokes,[6] however, and Stokes[8] were unable to produce hepatitis in volunteers after oral administration of filtrates of either nasopharyngeal secretions or urine obtained from patients during outbreaks of the disease.

There has been a large body of indirect evidence on the mode of spread of the disease accumulated in the literature describing outbreaks of infectious hepatitis in communities, schools, families and military installations. One of the most extensively studied was the occurrence of endemic hepatitis in nurses and children in a Chicago orphanage over a nine year period.[10,11] The investigators concluded that the mode of spread was from endemically infected infants by way of their stools to the nurses. This conclusion was based on the fact that cases in nurses abruptly ceased when proper hand washing was instituted, and the fact that no adults in contact with the nurses came down with hepatitis.

Warren[12] extensively reviewed the literature and analyzed the reports of 62 outbreaks according to the probable method of spread. He stated

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that in 12 it was concluded that the disease was spread by respiratory droplets, in 13 by unspecified contact transmission, and in 24 by enteric contamination of either food, water, milk or insects, and that in 13 the mode of spread was undetermined. This author concluded from his study that the evidence for spread by the respiratory route is inconclusive, and that in each epidemic so reported an enteric-oral route would have as easily or better explained the course of the epidemic. He concluded that the experimental and epidemiologic evidence supports only a theory of the enteric-oral route of spread of the disease.

In view of the fact that there are as yet no definite conclusions as to the exact epidemiology of infectious hepatitis, we submit the following description of a small outbreak observed by us.

Report of an Outbreak of Infectious Hepatitis

During a 10 month period there was a total of 29 cases of infectious hepatitis brought to the attention of the health authorities in the town of Avon Park. Since all the cases but 1 occurred in children under age 15, the morbidity rate was calculated for this age specific, per 1,000, per annum and is represented graphically in the accompanying charts (figs. 1-3). As can be seen from these the outbreak reached a peak in February 1953, with a preliminary rise in October 1952, one month after the beginning of the fall school term. The patients were seen by local physicians, and the disease was diagnosed clinically by the typical course of prodromal anorexia, abdominal distress, and fever for five to 15 days followed in all cases by an icteric phase which lasted on the average for 14 days. All cases were mild, there being no fatalities or serious prolonged morbidity. In only 1 case was the correct diagnosis in doubt since hepatitis from Leptospira canicola infection could not be ruled out.

The ages of the children ranged from 2 to 14, and there were 11 female and 17 male children in the affected group. Nineteen of the 28 children were of school age and attended the single elementary school in the town. All of the cases occurred in the white population.

Each case was investigated by a trained communicable disease investigator, and a special form was filled out containing information about previous illnesses, needle injections, blood or plasma transfusions water and milk supply, sanitary facilities, places frequented and contacts.

From the experimental evidence showing that the virus of infectious hepatitis is present in the blood, feces and possibly the nasopharyngeal secretions of the patient during the communicable phase of the disease, the following modes of transmission were postulated: (1) by blood, blood products, or syringes and needles contaminated with blood; (2) by carriers with infective stools; (3) by contaminated food, water, or milk; or (4) by direct contact, either with (a) respiratory droplets or (b) objects contaminated with feces by the hands of the infected person. We have attempted to analyze the possible occurrence of each of these methods as the mode of spread in the outbreak we have observed.

1. Blood, Blood Products, or Contaminated Needles. — In none of the cases observed was there a history of blood or plasma transfusion, or needle injections in the six month period prior to the onset of the disease. There was, however, a good chance for the disease to be spread via contaminated needles during an anemia and hookworm survey in the elementary school in March 1953. A small lancet was used and sterilized only by dipping in 70 per cent alcohol between each finger prick. It is realized that we are subject to justifiable criticism for allowing this survey to take place at this time. There was, however, no rise in the case rate in the month following this survey.

2. Carriers with Infective Stools or Other Body Excreta. — All workers in the two dairies serving the town from which all milk used by the children was purchased, all cafeteria workers in the school where the children had their noon meal each day, and all workers in the City Water Department were investigated for possible occurrence of the disease in themselves or their families during the months of the outbreak, and no cases were found. It is entirely possible that subclinical cases may have existed in these persons, however, since the investigations included no laboratory work.

3. Contaminated Water, Food, or Milk.— The water supply of each of the homes in which cases occurred and in the school was from the public mains. The public water supply is derived from deep wells and pumped directly into the mains without chlorination. Monthly samples are sent in to the Florida State Board of Health Laboratories for analysis and during the 10 month period covered by the outbreak all of the 30 samples submitted were reported as having less than 2.2 coliform organisms per 100 ml., which

is satisfactory (fig. 1). Without chlorination, however, it is entirely possible for significant fecal contamination to have occurred at times other than when samples were submitted, and this occurrence is most likely when breaks occur in the mains. The location of all breaks in the mains during the months of the epidemic were analyzed according to the location of the homes of the infected children, and no correlation was found. Furthermore, the sanitary facilities in each of these homes were satisfactory, being either an approved septic tank, or connected with the public sewer system. Also, the cases were plotted on a map showing the course of the water mains, and there was no apparent relation between the two factors.

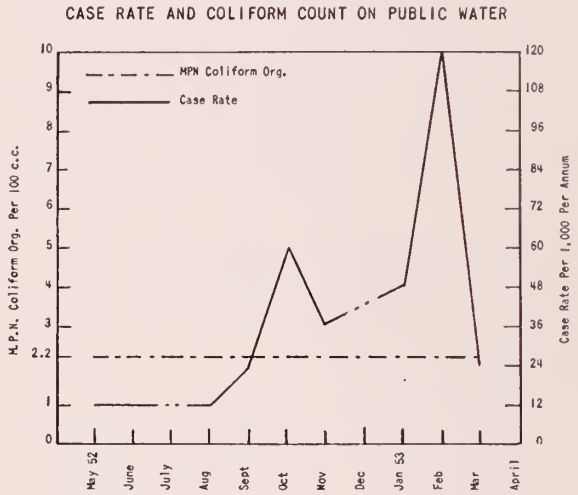


Figure 1.

All milk in the city of Avon Park is supplied by two major dairies and one minor dairy. Only the two major dairies supplied the milk to these families, and the reports on the bacteriologic analysis of their milk samples by the Florida State Board of Health Laboratories during the months of the outbreak are summarized in figure 2. It is believed that these show that there is no correlation between the bacteriologic purity of the milk supply and the outbreak of infectious hepatitis as reflected by the case rate. It can be seen that there was a gradual improvement in the reduction of the coliform count contrasted with the rise in the case rate. This together with the fact that no cases of hepatitis were found in the dairy workers or their families leads us to conclude the disease was not spread by fecally contaminated milk.

4. Spread by Direct Contact. — The virus of infectious hepatitis can presumably be transmitted either by direct contact with (a) objects contaminated with infective feces, or (b) respiratory droplets. The feces can remain infective apparently for a month or longer, whereas it is presumed that the nasopharyngeal secretions are infective for only a short time during the late prodromal or early acute phase of the disease. It must be emphasized that this is only a presumption. This observation is significant only in the fact that if transmission were primarily by respiratory droplets, most secondary cases would be expected to occur within the 30 day period following

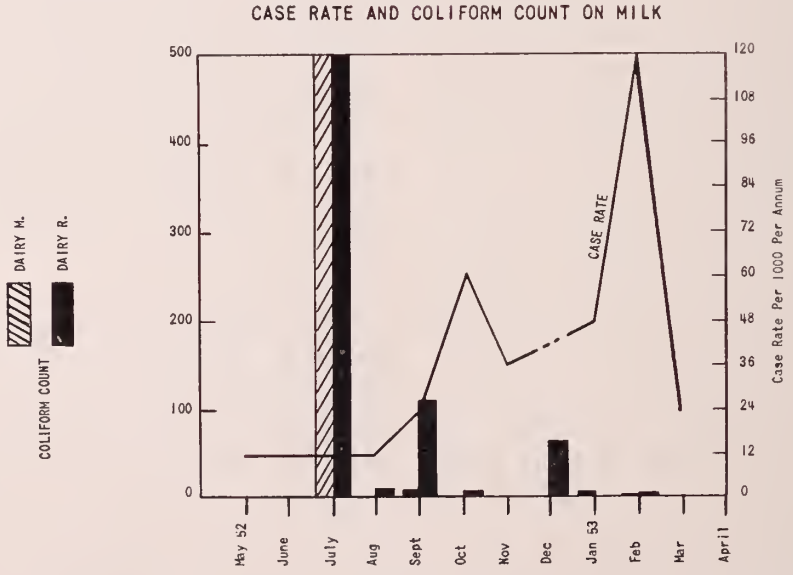


Figure 2.

the acute phase of the initial case. On the other hand, if the spread was by contaminated feces, secondary cases would appear anywhere from 30 to 60 days after the primary case.

In the outbreak observed by us, the evidence appears to point to a direct contact spread, but it is not conclusive whether this was by respiratory droplet or enteric contamination. The evidence for direct spread is as follows: Of the total 29 cases, in 21, or 72 per cent, there was a history of direct personal contact, either in the home or school, with a person known to have the disease within the known incubation period, namely, 10 to 40 days. In all cases the average incubation period, on the basis of this information, was 29.6 days. Of the 21 cases with a history of direct contact, in all but 3 it was with a person of the same sex. Two of these 3 had contact with persons of the opposite sex, but in the same family group. We believe that this shows other than random selection, and is explained by the fact that children of grade school age have intimate contacts usually only with members of the same sex.

The cases were concentrated in a few families. Eight families had 72 per cent of the total number of cases. In 10 of these 21 cases there was a history of contact with another affected member in the family 30 days prior to the onset of the illness. The breakdown of the cases in the different families is as follows: One family had 5 cases, two families had 3 each, and five had 2 each. In only two families was an attempt made to prevent infection with prophylactic gamma globulin as described by Stokes and his associates,[13] Brooks, Hsia and Gellis[14] and Ashley.[15]

The cases also were concentrated in children of school age. Nineteen of the 29 cases were in such children, and in 17 of the 19 the children were in grades one to six. There are 18 classrooms for the children in the first to the sixth grade, and pupils in only 7 of these rooms were involved in the outbreak. The school is physically divided so that the first three grades are in one building having a common lavatory, and 11 of the 17 cases in children in the first six grades were in this building. Although this concentration of cases in children in a few rooms could have been due to common exposure to a single source such as a contaminated supply of water, this was thought not to be the case for the following reasons. The outbreak was not explosive, but spread over a period of 10 months. In the months with the highest number of cases, October and February, in 6 of the 9 reported cases there was a history of personal contact with a person known to have the disease in the month prior. Moreover, in 5 of the 19 cases in children of school age observed over the entire course of the outbreak there was a history of direct contact with another child in the same room who came down with the disease an average of 37.5 days previously. In 10 of the 19 cases there was a similar history, only with persons outside the schoolroom. There remain only 4 of the 19 cases which cannot be accounted for a direct person to person method of spread.

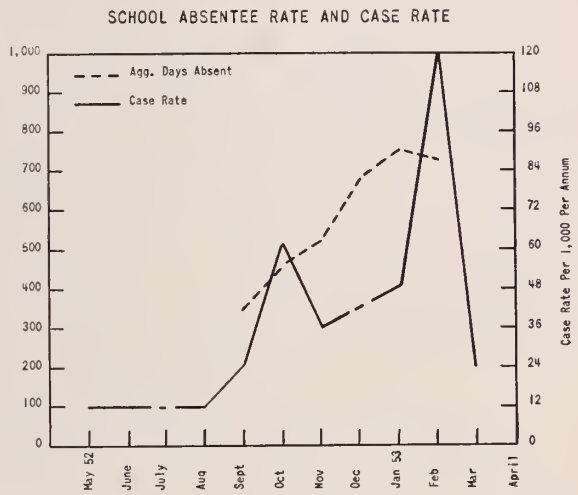


Figure 3.

Discussion

Although we believe that the evidence points to the fact that the virus was spread by direct contact either in the home or school, we cannot say with any clarity whether the spread was by respiratory droplets or fecal contamination. The evidence in favor of respiratory droplets is as follows: During the late winter and early spring months, the community suffered from an influenza outbreak similar to that occurring in other parts of the nation at that time. There are no reliable statistics on the number of cases occurring during that time, but we think that a good index of these can be found in the absentee rates for the school during those months. Figure 3 shows the aggregate days absent (total number of pupils absent times number of days absent) for the months September to April. It can be safely assumed that 90 per cent of these absences during December, January and February were due to respiratory diseases. It can be seen that the curve closely coin-

cides with that of the infectious hepatitis case rate, reaching its peak one month prior to the latter, which would be in accord with the theory of respiratory spread. The uniform incubation period of 29.6 days found in the cases with histories of direct personal contact favors the concept of respiratory spread as mentioned previously.

On the other hand, there is equally good reason to think that the infection could have spread by contact with fecally contaminated objects. It is well known that children have little restraint about placing objects in the mouth. An ideal mode of spread would be via water faucet handles in lavatories. There were no foot-controlled faucets in the school these children attended. In the early months of the outbreak before it had aroused much attention, many of the children with the disease were sent back to school within two weeks after the onset of jaundice, thus affording ample opportunity to infect others via their stools. In January it was recommended by the Health Department that all children be kept home a minimum of three weeks after the diagnosis of the disease to obviate this possibility. We found no evidence in this outbreak which would tend to refute the possibility of enteric-oral spread.

Conclusions and Summary

An outbreak of 29 cases of infectious hepatitis, primarily in children under the age of 15, is described.

It is concluded that the evidence points to the fact that the disease was spread by direct person to person contact in the home or school. Spread by blood and blood products, carriers, and fecal contamination of water or milk is thought not to have occurred in this outbreak. This outbreak does not answer the question as to whether person to person spread occurs by respiratory droplet or enteric-oral contamination, but it is thought that the evidence is equally good for either mode.

To prevent the occurrence of such outbreaks in the future it is recommended that gamma globulin in a dosage of 0.01 cc. per pound of body weight be given to all intimate contacts of persons having infectious hepatitis and that all those with the disease be segregated from the other unprotected school children a minimum of three weeks after the diagnosis is made.

We are indebted to Drs. Isaac W. Chandler, Hubert W. Coleman, Samuel A. King, Carl J. Larsen, and Donald C. Hartwell, who diagnosed and reported the majority of the cases; to Mrs. L. E. Rankin, P.H.N., who assisted in the investigations; and to Miss Jeanette Washburn, who prepared the charts.

References

1. Havens, W. P. Jr., and Ward, R.: Failure to Transmit Infectious Hepatitis to Chimpanzees, Proc. Soc. Exper. Biol. & Med. 60:102-104 (Oct.) 1945.
2. Andersen, T. T., and Tulinius, S.: Etiology of Hepatitis Epidemica (Epidemic Jaundice), Acta. med. Scandinav. 95: 497-509, 1938.
3. MacCallum, F. O., and Miles, J. A. R.: Transmissable Disease in Rats Inoculated with Material from Cases of Infective Hepatitis, Lancet 1:3-4 (Jan. 5) 1946.
4. Siede, W., and Meding, G.: Zur Atiologie der Hepatitis epidemica, Klin. Wchnschr. 20:1065-1067 (Oct. 25) 1941.
5. Havens, W. P. Jr.: Period of Infectivity of Patients with Experimentally Induced Infectious Hepatitis, J. Exper. Med. 83:251-258 (March) 1946.
6. Neefe, J. R., and Stokes, J. Jr.: Epidemic of Infectious Hepatitis Apparently Due to Water Borne Agent; Epidemiologic Observations and Transmission Experiments in Human Volunteers, J. A. M. A. 128:1063-1075 (Aug. 11) 1945.
7. Droller, H.: Outbreak of Hepatitis in Diabetic Clinic, Brit. M. J. 1:623-625 (May 5) 1945.
8. Stokes, J. Jr.: Epidemiology of Viral Hepatitis A., Am. J. Public Health 43:1097-1100 (Sept.) 1953.
9. MacCallum, F. O., and Bradley, W. H.: Transmission of Infectious Hepatitis to Human Volunteers, Lancet 2:228 (Aug. 12) 1944.
10. Capps, R. B.; Bennett, A. M., and Stokes, J. Jr.: Prolonged Outbreak of Infectious Hepatitis in Nurses Due to Small Group of Children Serving as Reservoir of the Virus, J. Clin. Investigation 29:802-808 (June) 1950.
11. Bennett, A. M., and others: Endemic Infectious Hepatitis in an Infants' Orphanage. II. Epidemiologic Studies in Infants and Small Children, A. M. A. Arch. Int. Med. 90:37-53 (July) 1952.
12. Warren, W. R.: The Epidemiology of Infectious Hepatitis, U.S.A.F. Med. J. 4:313-336 (March) 1953.
13. Stokes, J. Jr., and others: Infectious Hepatitis; Length of Protection by Immune Serum Globulin (Gamma Globulin) During Epidemics, J. A. M. A. 147:714-719 (Oct. 20) 1951.
14. Brooks, B. F.; Hsia, D. Y., and Gellis, S. S.: Family Outbreaks of Infectious Hepatitis; Prophylactic Use of Gamma Globulin, New England J. Med. 249:58-61 (July 9) 1953.
15. Ashley, A.: Gamma Globulin; Effect on Secondary Attack Rates in Infectious Hepatitis, New England J. Med. 250: 412-417 (March 11) 1954.
16. Gellis, S. S., and Hsia, D. Y.: Viral Hepatitis, New England J. Med. 249:400-409 (Sept. 3) 1953.

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Tetanus in Dade County Ten Year Survey

C. J. Mathes, M.D.
MIAMI

While the national total of cases of tetanus reported in 1952 was not alarming, it is notable that Florida led all other states in the number of reported cases. For the nation as a whole, there were 484 cases, Florida reporting 46 cases, Alabama second with 44 cases and California third with 43 cases. It is true that many diseases were much more prevalent than tetanus, but it is also true that few of these diseases bear the high mortality that occurs in tetanus.

In Florida, of the 46 reported cases 27 terminated fatally, a mortality of 58.6 per cent. Of the deaths, 22 occurred in the Negro and 5 in the white population.

A study of tetanus in Dade County for the 10 year period 1943-1952 is presented here. During this decade 99 cases were reported, a yearly average of 9.9 cases. Of this total 96 cases occurred in residents and 3 in nonresidents. Of the 35 cases among the white population, death occurred in 14. There were 8 males and 6 females in this group. Sixty-four cases with 36 deaths occurred among nonwhite persons. One of these fatalities was in a nonresident. In this group there were 24 males and 12 females. In the 99 cases 50 deaths occurred from the disease, which was 50.5 per cent fatal. Table 1 shows the number of deaths by age groups, table 2 the death rate and table 3 the mortality by sex and race.

Table 1. — Tetanus Cases and Deaths by Age Periods

Years	Cases	Deaths
Under 1	10	10
1 - 9	22	8
10-19	12	4
20-29	6	2
30-39	12	5
40-49	8	5
50-59	15	7
60-69	9	6
70-	5	3
Total	99	50

The classical clinical picture described was derived from the study of 29 cases in which the patients were hospitalized at Jackson Memorial Hospital in Miami. The main complaints or signs universally found in these patients were: (1) inability fully to open the mouth, with difficulty in swallowing, and (2) muscle spasms or convulsions with stiffness in the neck and abdominal muscles. The incubation period from the date of injury to the onset of symptoms varied from three days to three weeks.

Table 2. — Death Rate

	Cases	Deaths	Per Cent Mortality
First five years (1943-47)	50	33	66
Last five years (1948-52)	49	17	34

Table 3. — Mortality by Sex and Race

	Cases	Deaths	Per Cent Mortality Cases in Group
White male	20	8	40
White female	15	6	40
Nonwhite male	40	24	60
Nonwhite female	24	12	50
Total	99	50	

The portal of entry, though in some cases open to controversy, was given as (1) penetrating wounds of the foot: sandburr, splinter of wood and nails; (2) burns; (3) lacerations; (4) B.B. shot in scalp; (5) varicose ulcer; (6) abortion; (7) following surgery of the finger, and (8) the umbilicus in the newborn. Excerpts from the cases reviewed at Jackson Memorial Hospital are illustrative:

A 2 year old white boy, burned 13 days prior to admission, had been treated but given no antitetanus serum. One day prior to admission, he complained of pain and stiffness of the neck. On admission, he could not open his mouth. All of his muscles were rigid with spasm and pain on motion.

A 10 year old Negro boy, with a history of injury to the right wrist two weeks prior to admission causing a small laceration, complained of sore throat for three days. On the day prior to admission, he could not open his mouth and complained of pain in his stomach. On the day of admission his back was stiff.

Assistant Health Commissioner, Department of Health, Dade County Health Unit.

An 8 year old Negro boy was admitted with the complaint of trismus, difficulty in swallowing and convulsions. He remembered stepping on a splinter of wood two weeks previously. The splinter was removed from the skin of the left heel, and the wound seemingly healed.

A 10 year old Negro boy had had his finger operated on three weeks previously. One week prior to admission, he began complaining of stiffness in the back and weakness of his legs.

A 36 year old white woman fell one week prior to admission, suffering a 1.5 cm. laceration over the left eyebrow. She complained of varying degrees of headache until the day before admission when her jaws became sore and stiff.

A 9½ year old Negro boy was admitted from another hospital with the diagnosis of tetanus. He had stepped on a burr while fishing 10 days previously.

A 70 year old Negro man complained of recurrent ulcer and infection of the right foot for the past 20 years. Four days prior to admission, his jaw became stiff, and he could not swallow. He grew progressively worse and on admission had much difficulty in talking.

A 25 year old Negro woman was admitted first three days prior to the second admission with the complaint of vaginal bleeding, diagnosed as a miscarriage. No dilatation and curettage were done. She was discharged with a record of complete abortion. When admitted three days later, she was unable to open her mouth, had nuchal rigidity, and complained of pain in her back. In this case 20,000 units of tetanus antitoxin was inserted into the fundus uteri.

A 58 year old Negro woman had a chronic stasis ulcer for many months. Eight days prior to admission she complained of cramps in the lower portion of the abdomen and pains in the thigh. The laboratory reported a colony of Clostridium tetani was isolated from a culture from the site of the ulcer.

An 11 year old spastic Negro boy nine months prior to admission had undergone surgery for correction of a deformity of the leg. A cast was applied. When the cast was removed, a draining wound was uncovered that persisted. Six days prior to admission, abdominal pain and loss of appetite were noticed. Difficulty in swallowing and trismus developed and continued to the time of admission, becoming increasingly severe.

These recitations point to the many possible portals of entry of tetanus infection, the variation in the incubation period, and the fact that tetanus occurs at any age and the signs, symptoms, and complaints are fairly classic.

In the fatal cases the most constant finding at autopsy was complications in the respiratory tract, with pulmonary edema and pneumonia reported in all but 1 of the 7 cases in which autopsy was performed. The pathologist's findings also included subdural petechial hemorrhage in about half of the cases.

Tetanus Neonatorum

The question of tetanus neonatorum in Dade County is particularly important in my estimation because of the 100 per cent mortality encountered. As table 4 indicates, there were 10 cases for this decade with 10 deaths. The average incubation period in these cases was seven days with variation from five to 12 days. Six of the infants were delivered by midwives, 1 was unattended, and 3 were delivered by physicians. Of the cases attended by physicians, 2 were in approved hospitals.

Table 4. — Tetanus Neonatorum

Year	Cases	Ages in Days
1943	2	9 and 12
1945	1	7
1946	2	7 and 12
1947	3	6, 7 and 8
1950	1	5
1951	1	9

The following is a representative case report by a Public Health nurse: "On Monday, I made a routine postpartum visit to F. N., a Negro, 28 years old, who was delivered at home by a midwife. This was the patient's sixth pregnancy. The newborn, male, was apparently normal at birth. The other five children, ranging in age from sixteen months to eight years, are females. All the pregnancies developed to full term, and the deliveries were spontaneous with no complications.

"I found the immediate surroundings in a filthy condition. Garbage was in the front yard. There were many cans, bottles, trash of all kinds in the backyard. The flies were numerous. The following morning I reported this condition to the Sanitation Department. The interior of the apartment was neat and fairly clean. There was running water, flush toilet and screens. The mother was greatly concerned about the outside conditions. At that time she said that they were planning to move as soon as she was strong enough."

The report of the findings concerning this baby as recorded on the infant's record was: "H. V. Apparently normal male child. Weight 7½ lbs.; temperature 99.8. Midwife attended; breast fed,

nurses well, water between feedings; umbilicus inspected, condition good; foreskin tight; elimination normal; skin moist; eyes clear; cries lustily."

The baby appeared to be perfectly normal until early Thursday morning. He nursed well at 4:30 a.m., eructated a large amount of gas and fell asleep. At 5 a.m. he awakened and cried hard. When the mother attempted to nurse him, thinking he was still hungry, she noticed that he did not seem able to open his mouth. She forced a few drops of milk into his mouth. He vomited that small amount and some phlegm. In a short time she forced a small amount of water into his mouth and then she realized that he could not open his jaws and that he was not able to swallow. The baby continued to be restless and fretful and cried hard at times. Many times the mother thought that he was in pain as "he drew up his legs and they remained stiff." She gave him a little water rectally, but this gave him no relief. The midwife came and took care of the baby, but she was not able to quiet him.

When the father came home from work in the evening, he took the child to the hospital, where he was admitted to the isolation ward. At that time he was told that the baby was critically ill. On Friday morning, the diagnosis of tetanus of the cord was made. The baby died on Sunday.

Ten Broeck and Bauer[1] stated that the placenta is permeable to tetanus antitoxin and that when the antitoxin is present in the mother's blood, it is also present in the cord of the newborn infant. It appears, therefore, that the administration of tetanus toxoid to the patient in the antepartum period would provide the newborn with immunity to tetanus and so decrease, if not obliterate, the incidence and therefore the mortality in tetanus neonatorum.

According to the best investigators, it takes from four to six months after the final injection of antigen for an adequate resistance to tetanus to develop. I have suggested, therefore, that the pregnant patients presenting themselves to the clinics in Dade County receive tetanus toxoid immunization as early as the third month and not later than the fifth month. Of course this program is not altogether feasible in clinic patients because, as is well known, they often do not visit the clinics until they are several months pregnant. In private practice where early presentation and better control of patients prevail, this suggestion may have some merit.

As the immunization program of the state becomes older, it is expected that these problems will diminish. In view of the time element necessary for this change to occur, it becomes apparent that tetanus immunization should be stressed by all branches of the medical profession.

References

1. Ten Broeck, C., and Bauer, J. H.: Transmission of Tetanus Antitoxin Through the Placenta, Proc. Soc. Exper. Biol. & Med. 20:399, 1923.

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ABSTRACTS OF MEDICAL ARTICLES

Intrathoracic Hibernoma: Third Reported Case. By J. Winthrop Peabody Jr., M.D., Joseph Ziskind, M.D., Howard A. Buechner, M.D., and Augustus E. Anderson, M.D. New England J. Med. 249:329-332 (Aug. 20) 1953.

Hibernoma is the term applied to a rare tumor composed of multiloculated fat cells morphologically similar to, if not absolutely identical with, the cells of the so-called "hibernating gland" of animals. A case of intrathoracic hibernoma is reported, which the authors believe to be the nineteenth proved case of this neoplasm and only the third in which it arose within the chest. The literature on hibernomas is reviewed briefly, and the possible relation between these tumors and the hibernating glands of animals is discussed.

The Low Transverse Muscle-Cutting Incision in Gynecological Surgery. By Gerald S. Williams, M.D. Am. J. Obst. & Gynec. 67:398-406 (Feb.) 1954.

Observing that a satisfactory abdominal incision should (1) provide adequate exposure, (2) respect anatomic structures sufficiently to produce the least possible damage to the abdominal wall, (3) be simple and allow for extension, and (4) be cosmetically acceptable to the patient, Dr. Williams points out the several basic advantages of the transverse abdominal incision in the surgery of pelvic lesions. He reviews a series of 96 cases in which low transverse abdominal incisions of the Maylard type were performed. It is his conclusion that this incision is based upon sound anatomic and physiologic principles and offers

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the following advantages: (1) better exposure, (2) easier closure, (3) a stronger wound, (4) less incisional pain, (5) lower morbidity and mortality, and (6) better cosmetic results. The one disadvantage noted is that it takes more time to enter the peritoneal cavity. Except for emergency laparotomy, the transverse incision is in his opinion the most logical approach to surgical treatment of pelvic lesions and should be used more frequently by the gynecologic surgeon.

Polycythemia Complicated by Brain Tumor. By Irwin Perlmutter, M.D., and Richard E. Strain, M.D. Neurology 4:398-401 (May) 1954.

Two cases are reported in which the patients exhibited signs and symptoms of intracranial difficulty caused by brain tumor and not by coincidentally existing polycythemia vera. In 1 patient signs and symptoms due to an intracranial mass were relieved temporarily by venesection for polycythemia. Polycythemia vera is a disease of unknown origin, characterized by an excessive production of all the marrow elements with resultant increase in red cell, leukocyte and platelet counts. It is commonly complicated by organic neurologic difficulties produced by (1) plethora and (2) thrombosis and hemorrhage. This disease of middle and later life may be accompanied by any of the diseases of these periods. Since brain tumor, primary or metastatic, occurs frequently in patients in these age groups, it is suggested that neurologic complaints in patients with polycythemia should be thoroughly investigated before they are diagnosed as due to vascular complications of the original disease. In the cases reported here, because of the length of time that the blood dyscrasia was present before appearance of the malignant neoplasm, the relationship between polycythemia and the tumor was regarded as certainly coincidental.

Creeping Eruption. By Lauren M. Sompayrac, M.D. South. M. J. 47:792 (Aug.) 1954.

The author summarizes some of the opinions of many of the dermatologists in Florida as to the efficacy of certain drugs used in the treatment of creeping eruption. He reports widespread uniformly disappointing results with Hetrazan and relates that he and two colleagues had only uniformly poor results on adequate trial in over 150 cases with Stibanose although they concluded that Stibanose was less toxic than Fuadin. Also, he and three colleagues tried oxytetracycline in 93 cases using various dosage schedules with only equivocal results.

Not only did the manufacturer cooperate in furnishing the material free of charge, but the Florida State Board of Health made studies on the larvicidal effect of Fuadin, Stibanose and Terramycin. None of these agents showed a complete larvicidal action in 24 hours. The nearest the investigators could conclude was that both Stibanose and Fuadin had approximately the same larvicidal action. The oxytetracycline at blood level showed only 15 per cent lethal effect after 24 hours.

So far, the author reports, the only treatment that has stood the test of time is the use of ethyl chloride spray. He would encourage other research on this problem, but cautions that many of the enthusiasts for a drug in the past apparently lost sight of the fact that in a goodly percentage of the cases cure is spontaneous.

Cardiac Arrest During Mitral Commissurotomy; Complete Recovery After Twenty-Four Minutes. By H. H. Seiler, M.D., H. G. Carron, M.D., and N. L. Marcus, M.D. A. M. A. Arch. Surg. 68:710-712 (May) 1954.

The purpose of this communication is to report an instance of cardiac arrest which per-

sisted for 24 minutes during the performance of commissurotomy for mitral stenosis. The action of the heart stopped just prior to entrance of the auricle with the index finger. During this long period adequate circulation was maintained by means of manual cardiac massage, and oxygenation was carried out by administration of 100 per cent oxygen under positive pressure. Following restoration of spontaneous cardiac action the surgical procedure was completed. The patient was returned to her room in a satisfactory condition, reacted promptly and completely from the anesthesia and showed no evidence of cerebral damage then or subsequently. The favorable outcome in this case despite the unusual length of time required for the heart to resume spontaneous action should encourage prolonged efforts in similar situations. The absence of any evidence of cerebral damage was perhaps due to the immediate institution of effective massage, as shown by palpable pulsations in the temporal artery.

Influence of Long-Term Bishydroxycoumarin (Dicumarol) Therapy on Liver Function. By Marvin L. Meitus, M.D., and Philip Wasserman, M.D. A. M. A. Arch. Int. Med. 91:464-473 (April) 1953.

Because they found in the literature only meager laboratory evaluations of the possible detrimental effect of long term bishydroxycoumarin (Dicumarol) therapy, the authors undertook the study here reported. Various abnormalities as shown by liver function tests existed in 45 patients, comprising three distinct groups, who had received bishydroxycoumarin for two days to 56 months and in 12 persons who had received no bishydroxycoumarin. A comprehensive evaluation disclosed no consistently large number of abnormal determinations with any one particular laboratory procedure, nor did any one patient under carefully managed bishydroxycoumarin therapy reveal pronounced abnormalities in all liver function tests.

Additional data demonstrated that severe prothrombin deficiency induced by overdosage of bishydroxycoumarin produces toxic liver damage, which, however, is only temporary and is completely reversible.

Long term bishydroxycoumarin therapy produced no conclusive evidence of appreciable hepatic parenchymal damage in patients who previously had not suffered from hepatic disease.

Rabies in Bats in Florida. By Homer D. Venters, Warren R. Hoffert, James E. Scatterday, D.V.M., and Albert V. Hardy, M.D., F.A.P.H.A. Am. J. Pub. Health 44:182-185 (Feb.) 1954.

This study of the prevalence of rabies in apparently normal bats of varying species collected for examination in two areas of Florida in 1953 was occasioned by an attack on a 7 year old boy on a ranch in central Florida by a lactating female Florida yellow bat (Dasypterus floridanus), a species heretofore considered relatively rare. The child had a severe illness of sudden onset 28 hours after being bitten by the bat, characterized by early symptoms of nausea and vomiting with severe shock rapidly following. Stools were loose and contained much blood. The temperature rose to 102 F. four hours after the onset. During the period of hospitalization, intravenous glucose and saline were administered, and several laboratory tests gave findings within normal limits. After about six hours of illness, the symptoms began to subside, and the next day the boy appeared to be well. Rabies immunization was started thereafter, and the subsequent history was uneventful.

Of 208 apparently normal noncolonial bats, all shot in central Florida, 6 were found positive for rabies, 5 being Florida yellow bats and 1 a Seminole. Extensive laboratory investigations at various laboratories disclosed that bat brains negative for Negri bodies may be positive for rabies by mouse inoculation and bat brains negative for rabies by mouse inoculation may have brain inclusion bodies which cannot be securely differentiated from Negri bodies by microscopic examination alone.

Contrary to prevailing opinion among biologists as to the rarity of the yellow bat, it was the species most commonly found during the summer months in the central area of Florida studied. It is concluded that the direct exposure of human beings to rabies by bats in Florida or the United States is a minor hazard, but a risk which must be acknowledged. The knowledge that rabies occurs in the insectivorous free-living bats in Florida adds another facet to an old and complex problem which invites further laborious and prolonged studies.

Anal Fistula, Anatomical and Surgical Considerations. By George Williams Jr., M.D. South. M. J. 47:665-673 (July) 1954.

In this comprehensive presentation of the anatomic and surgical aspects of the subject of anal fistula, the author emphasizes that the primary objective in fistula surgery is to eradicate the infection, but that it is equally important to preserve good muscular function. He discusses the pathogenesis and etiology of this condition, observing that whatever initially may cause the break in the protective lining of the anal canal, it is bacterial infection which eventually produces the fistula. Detailed anatomic description and the various surgical considerations follow under the headings of regional anatomy, the levator musculature, the para-anal and pararectal surgical spaces, general surgical considerations of fistula surgery, fistula surgery from an anatomic basis, and infections of the supralevator spaces.

Cystogastrostomy for Pancreatic Cyst. Report of a Case. By Timothy A. Lamphier, M.D., William Wickman, M.D., and N. Gillmor Long, M.D. A. M. A. Arch. Surg. 68:666-676 (May) 1954.

In this article the etiology, means of diagnosis, and treatment of pancreatic cysts are reviewed, and a case of successful pancreatic cystogastrostomy is reported. A review of the world literature disclosed that the anastomosis of a pancreatic cyst to the stomach is a rare operative procedure, reported only 55 times. This study indicates that surgical intervention is the treatment of choice in every case of suspected or proved pancreatic cyst. Prior to laparotomy, one cannot determine whether carcinomatous degeneration of a cyst is present. Conservative therapy has proved unsatisfactory because of the untoward sequelae and also because of the possibility of rupture of the cyst into the peritoneal cavity, with the attendant mortality of approximately 60 per cent.

It is agreed that in the case of a small cyst, especially one in the tail of the pancreas, or a cyst appearing to be easily removable technically without too great a risk of injury to the surrounding vital structures, pancreatectomy is the best treatment whenever possible.

In cases unsuitable for excision, simple drainage by means of a large rubber catheter, a cigarette drain or marsupialization may be used despite the many disadvantages of this management, such as the persistence of draining fistulas, the excoriation effect of pancreatic juice on the skin, and the tendency to recurrence. The method of internal drainage by anastomosis of the cyst wall to the stomach, used in the case reported, obviates the disagreeable features of external drainage and insures adequate drainage. Following pancreatice cystogastrostomy, abnormalities of the stomach at the site of the anastomosis are not demonstrated roentgenologically and eventually the cystic cavity atrophies and disappears.

Cardiac Arrhythmias in the Aged. By Sidney Storch, M.D., and Ziang Tsien Tang, M.D. Am. Pract. & Digest Treat. 5:367-373 (May) 1954.

In this study the electrocardiograms of 522 elderly institutionalized persons were analyzed. In summary, the authors stress the frequency and significance of arrhythmias in the aged. In the treatment of auricular tachycardia they found intravenous Lanatoside C to be most effective and concluded that Mecholyl, carotid sinus stimulation and Neosynephrin have little place in its treatment in these patients. They advised trying procaine amide (Pronestyl) before quinidine in the ventricular arrhythmias and regarded the age of the patient no reason for withholding quinidine when indicated, as in paroxysmal auricular fibrillation or flutter. For digitalization, Digoxin is their preference, and for maintenance Digoxin or Digilanid if trial proves the patient can be maintained on these digitalis preparations.

In dealing with the arrythmias, they always consider the possibility of multiple cardiac pathologic changes, such as coexisting rheumatic, syphilitic, thyrotoxic heart disease and nutritional or even congenital heart disease. Other observations and conclusions were: Wolff-Parkinson-White-like electrocardiograms, not rare in this age group, may be associated with a higher incidence of paroxysmal tachycardias. Strophanthin may be given in treating patients with cardiac arrhythmias and heart failure. Oxygen is a valuable adjunct in the treatment of arrhythmias in the aged. Complete atrioventricular dissociation is often well supported by the aged patient and may need no specific treatment.

Benign and Precancerous Lesions of the Breast: Practical Management. By Richard M. Fleming, M.D., and Rudolph E. Drosd, M.D. South. M. J. 47:922-928 (Oct.) 1954.

In considering the practical approach to the management of certain nonmalignant breast lesions, the authors analyzed a series of 1,120 private cases in which the patients consulted them for complaints primarily referable to the breast. The diseases they encountered were carcinoma, 159; mastodynia, 96; fibroadenoma, 61; intraductal papilloma, 36; Schimmelbusch's disease, 14; and a miscellaneous group including lipoma, fat necrosis, duct stasis, abscess and granulomas, 316. They present a brief outline of the pathology of these various lesions, except carcinoma and the miscellaneous group, with an analysis of their symptoms and signs as well as their relation to cancer.

Carcinoma as a sequel to benign breast disease occurred in only three instances in the series: once in a breast from which a fibroadenoma previously had been excised, once in a breast where fibrocystic disease existed previously, and once in a breast which presented Schimmelbusch's disease on pathologic study although it had been considered to be fibrocystic disease prior to surgery. The association of carcinoma with Schimmelbusch's disease in three instances is noteworthy although the authors had not observed transition to carcinoma in any previously diagnosed Schimmelbusch's disease.

They conclude that the likelihood of the development of carcinoma is only slightly greater in those breasts presenting various manifestations of cystic mastitis than in normal breasts and that the benign and so-called precancerous lesions of the breast can be safely managed by conservative measures or limited surgical procedures in most instances. For the management of such lesions they present a method of procedure. Also, they suggest that cytologic study of nipple secretions and aspirations of cysts and other breast masses is a newer helpful device in managing certain of these cases.

Functional Illness — Medical Enigma. By Robert J. Needles, M.D. J. A. M. A. 156:585-589 (Oct. 9) 1954.

Physicians need to devote more time to the study of patients who are seldom cured and infrequently happy or satisfied, declares Dr. Needles. His excellent analysis of the problem of functional illness leads him to conclude that the medical profession, with all its progress, needs outside help on the problem of emotionally ill, displaced, abandoned, chronically unhappy, or otherwise handicapped persons. Physicians can suggest, advise, warn, but they cannot go with these persons into the community and lead them into new interests and new drives to demonstrate reasons for living. The responsibility here lies with society. Excessive wastage of human resources in the communities' own back yards call for practical and interesting demonstrations of how best to use increasing amounts of leisure time. Such measures would help to reduce the amount of functional illness. Likewise, it would help to remove a potential threat to the private practice of medicine for sufferers from functional distress, the profession's greatest reservoir of ill will, may well form the largest bloc of supporters of government intervention in medical practice.

Dr. Needles' plea is that physicians recognize how many persons there are whom they have not helped by drugs or surgery and how greatly these persons suffer despite efforts of the medical profession to care for them. Then this author would have physicians stimulate renewed inquiry into the causes of functional disorders and, instead of assuming the blame for failure to cure, point out that the trouble may be with society, with man's conversion into a modern wanderer uprooted from his past, his old assurances and prejudices washed away and not replaced by new solidity. To Dr. Needles it seems a bit foolish for physicians to castigate themselves and allow others to castigate them for the emotional illness of a sick society. Physicians, he believes, should assert the fundamental nature of the problem and, by doing so, aid in the elimination of this modern pestilence.

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Walter C. Payne Sr., M.D., 1949.....*Pensacola*
Herbert E. White, M.D., 1950.....*St. Augustine*
David R. Murphey Jr., M.D., 1951.....*Tampa*
Robert B. McIver, M.D., 1952.....*Jacksonville*
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The Editor's Wastebasket

Many a would-be medical author is puzzled at the rejection of his manuscript. He finds the vagaries of the editorial mind unfathomable. For enlightenment he may turn to a refreshing article in the January 1955 Medical Economics entitled "Medical Articles I Never Finish Reading" by Dr. Henry A. Davidson, the editor of the Journal of the Medical Society of New Jersey. Congratulations to Dr. Davidson for his frank analysis of the faults which lead to rejected articles. His is by no means the only editor's wastebasket "stuffed with the writings of doctors who won't stick to the point and keep it simple." In his explanation of what makes these literary efforts unreadable any author may pick up gold nuggets of advice.

Scientific prose, he insists, need not be dismal. Real effort can make it readable, even pleasantly so. Readability begins with the title; if short, revealing, and specific, it will lead the reader into the first paragraph of most anything. If, however, that paragraph is an apologetic opener or a yawn producer, why should the editor go beyond the point where he knows the reader will stop? Like the title, the opening paragraph, and the whole article for that matter, must say something — and say it both directly and simply. Strangely enough, the doctor who is a straight shooter, a good doctor and a plain talker is frequently inclined to fancy language when he gets "literary." In his effort to impress, he becomes instead hard to understand.

Particularly objectionable is the out-of-this-world brand of medical writing, which Dr. Davidson is not alone in stubbornly resisting. If it spirals miles above the editor's whirling head, what heights would it attain above the average reader's head? It is astonishing how the plain, practical, clear-spoken surgeon, for example, can "fly off — and crash — on a tangent," display an addiction to hackneyed phrases and exhibit a genius for using ponderous words. It appears, too, that higher standards of medical education do not seem to be promoting a simpler style of medical writing. This editor finds the modern passage may be as dull as the older one is lively and precise in some instances.

In addition to these major flaws of much medical writing, there are minor complaints. "No one exhibit in the following chamber of horrors,"

says Dr. Davidson, "will turn me forever away from a medical article; but when they appear in combination, I generally make a fast exit." There is the space-wasting build-up — such space thieves as "I am convinced that . . ." or "Doctors generally recognize that . . ." Such meaningless locutions make the reader restless. Too, why Latin phrases instead of plain English — "in situ." "modus operandi" and the like? Why "morbilli" for "measles," "pyrexia" for "fever," and "etiology" for "cause"? "And when a doctor writes 'pes planus' for 'flat feet'," this editor declares, "I simply refuse to trust him. He's clearly a mannered pedant. . . . 'Gallstones' is English; 'cholelithiasis' isn't. And any writer who says 'podagra' when he means 'gout' would probably say 'agrypnia' instead of 'insomnia'."

In addition, there is no booby trap in medical writing so dangerous as the loosely used abbreviation. Does "P. A." mean "pernicious anemia," "posteroanterior," or "paralysis agitans"? And there is the simple letter "O," which can stand for eye, pint, oxygen, an electrode opening, or a blood group without agglutinogen. Split second percentages also cause Dr. Davidson to look askance; he is satisfied with a recovery rate of 87.1 per cent rather than one of 87.13 per cent. His final minor complaint is against the editorial "we." He cannot resist a raised eyebrow in the direction of the solo practitioner who grandiloquently announces: "We have had good results with . . ." when he really means, "I have had. . . ." "Does he expect me to believe," asks this outspoken editor, "he's a one-man Mayo Clinic?"

In this clear delineation of the common faults in medical writing which often mean rejected manuscripts medical editors across the country will concur. Too, they will wish this article were required reading for the contributors to their journals.

"Early Medical History of Dade County" Published by Pioneer Miami Physician

A unique contribution to the medical, educational and agricultural history of South Florida, just off the press, is reviewed in the Books Received section of this issue of The Journal. The major section of the book, entitled "Early Medical History of Dade County," portrays the early days of medicine in Dade County in graphic detail. The author, Dr. John G. DuPuis, is a pioneer Miami physician, who was a founder and past president of the Dade County Medical Association. He arrived in Dade County just two years after Henry M. Flagler's first train reached that section and began the practice of medicine at Lemon City, a village of some 250 inhabitants, on Oct. 29, 1898. A native Floridian, born at Newnansville on Sept. 22, 1875, he received his medical education in Kentucky and since his graduation has been actively engaged in medical practice in Dade County for 56 years. The historical record he has set down covers the early years of the Dade County Medical Association, of which the records were lost, and much other information.

Dr. DuPuis has rendered a real service to Florida medicine and to the state in compiling records from many sources and publishing his book. Pioneer days are relatively so recent in Florida, especially the southern section of the state, that a goodly number of senior residents could make a valuable contribution to posterity by recording their memoirs, as Dr. DuPuis has done.

A.M.A. Commendation of Eisenhower on Health Message

Except for his request for a bigger United States contribution to World Health Organization, President Eisenhower's special health message on January 31 carried no recommendations that had not been made earlier in his state of the union or budget messages. Scheduled to begin hearings early last month on the Administration's health program, the House Interstate and Foreign Commerce Committee expected Mrs. Hobby, the first witness, to outline all of the Administration's goals. Subsequently the various titles in the Eisenhower omnibus health bill and related separate bills were to be taken up one at a time. Chairman Priest expected to head the Health Subcommittee.

The American Medical Association, through its Board of Trustees, commended President Eisenhower on his special health message and pledged continued support to improve the health of the nation through strengthening medical efforts at the state and local levels. Specifically, the Association endorsed six of his objectives. It deferred action on two bills to allow for study and reaffirmed its position that reinsurance would "not achieve the desired results."

No policy stand was taken on the President's proposals for a new arrangement for the medical

care of public assistance recipients, or for federal guarantee of mortgages on health facilities because more time was needed for study. The A.M.A. is supporting or agrees in principle with Mr. Eisenhower's recommendations for an enlarged mental illness program, the training of more nurses, a more effective rehabilitation program, a new procedure for allocating public health grants, traineeships in public health and strengthening of the Public Health Service commissioned corps, and more research in air and water pollution.

Disability Provisions Now Included in Social Security Law

Physicians will wish to know about a new amendment to the Social Security Act which pertains to disability provisions. The information has kindly been furnished by Mr. R. B. Donaldson, District Manager, Social Security Administration, Jacksonville, in the following statement:

A recent amendment to the Social Security Act, permitting certain wage earners to establish periods of total disability lasting for more than six months, will be of interest to physicians. The amendment is not for the purpose of paying disability benefits. It will, however, enable the Bureau of Old-Age and Survivors Insurance to delete periods of total disability from a wage earner's record. Not charging this time to a disabled wage earner will tend to increase his benefit at retirement as well as increase benefits that may be paid his survivors should he die before age 65.

In all cases proper medical reports and evidence must be secured by the wage earners applying for this consideration. Physicians and clinics who have treated such persons will be visited by former patients. The patient will visit his physician, bringing with him any necessary forms to be executed.

Local social security offices will screen out persons whose participation in employment covered by social security is insufficient to meet minimum requirements of the new law. Only those who meet proper qualifications and can likely profit from this change will be advised to secure medical data.

Dr. W. J. Creel Day Celebrated in Eau Gallie

Washington's Birthday, 1955, took on particular significance for the citizenry of Eau Gallie for it was designated Dr. W. J. Creel Day. The Harbor City was proud to pay homage to its leading citizen, who through the years gave unstintingly of his services as country doctor and civic leader. It was also proud that the highlight of the all day celebration was the formal dedication ceremony, complete with fish fry, parade and talks by many dignitaries, which marked the naming of its new causeway the Dr. W. J. Creel Bridge. The impressive span, crossing the Indian River, links Eau Gallie with the Atlantic Coast beaches and the Patrick Air Force Base. This steel and concrete structure will long bear testimony to future generations of one who, for nearly half a century, put selfish ambitions aside and worked ceaselessly toward the betterment of the community he loved. Fittingly enough, the State Road Board joined the city in honoring this pioneer doctor by naming the bridge for him.

A native of Carrollton, Ga., where he was born on April 11, 1880, Dr. Creel came to Florida in 1908 after graduation from the Atlanta School of Medicine. For two years he practiced at Bayard in Duval County, where his mode of transportation was a mule and cart. For night travel he was dependent upon lightning bugs and the mule's good sense. When he went to Eau Gallie to practice in November 1910, he was the only doctor between Cocoa and Fort Pierce. There he moved up a rung on the transportation ladder by acquiring a horse and buggy, but frequently it was necessary to use a boat in his practice.

Soon the new doctor was a school trustee, and he served in this capacity until 1932, when he became a member of the school board, retiring from that position in 1954. Dr. Creel served numerous times on the city council and also as mayor. In 1927 he represented the district in the legislature. It was, however, almost immediately upon his arrival in Eau Gallie that he began striving for improvement, and in 1923 his first dream was realized — the wooden span connecting the town with

the island, a creditable structure for its day. Its inadequacy for the motor vehicle era set Dr. Creel to striving for a new and better bridge. For years there was delay after delay, but today the Dr. W. J. Creel Bridge stands as a monument to this intrepid country doctor, tangible expression of his interest in the community of his choice and his love for its people.

Perhaps the high moment of triumph came for Dr. Creel on the morning of February 1 when he stood at the approach of the span that bears his name, saw the barrier removed, and then made the first trip over it. At the brief informal opening ceremony at that time he stood with his two year old grandson in his arms, representing the past, the present, and the future, as his wife and daughter stood beside him while tribute was paid him for service well done.

Dr. Creel is a man whom his fellow townsman, Council President Lang Goodyear, could hold up as an example before the graduating class of the local school and eulogize in these words: ". . . an humble and upright man. . . . With all his arduous duties as a country doctor, this physician found time to participate in civic activities. He joined clubs and organizations, and sought neither to be the leader nor just a dues-paying member. He took an active part in any undertaking into which he entered. He did not seek publicity, nor perform good deeds to get his name into the newspapers. Rather he used his various civic groups as further means of service.

"He went quietly along, loving his family and his friends and his neighbors — tolerant of their weaknesses and lapses from grace, sympathetic in their hours of trial and sorrow. . . . This doctor took a particular interest in the youth of his community. . . . Burdened as he was with cares and duties and responsibilities, he maintained a firmness of character. He was salty of humor, soft enough to be sentimental, firm enough to fight wrongdoing and evil, human enough to overestimate the size of the pompano he caught or the wild turkey he shot. . . .

"I hope that someday every member of this class will think back on our good friend, Dr. William J. Creel, and say to himself, 'He was a mature man who lived humbly for a cause — the cause of service to his fellow man. May I dedicate myself humbly to this cause.' "

Well done, good and faithful servant. Your medical confreres salute you.

A Bit of Favorable Information on Physicians' Fees

An informative article on "What It Costs People To Be Sick" was published in the December 24 issue of U. S. News & World Report. Figures quoted were "based on the latest study of the Social Security Administration brought current through estimates by the Economic Unit of U.S. News & World Report." This special article contained some favorable information on physicians' fees:

"Government experts attribute most of the rise in hospital expense to higher charges resulting from better pay scales for hospital workers and the higher cost of food.

"Dentists and physicians, on the other hand, are getting a somewhat smaller share of the nation's private medical outlays. This finding runs counter to criticism of physicians' fees.

"Physicians' fees used to account for 30 per cent of the out-of-pocket cost; now they are 29 per cent. Dental bills are less than 10 per cent today, compared with more than 12 per cent in 1948.

"These fees tend to stay fairly constant for periods of years. The last big jump came during World War II. Today many physicians are charging the same for office calls and sickroom visits as they did shortly after the war."

Medical care, according to this report, costs a total of 12.4 billion dollars a year, of which 2.1 billion is met through health insurance.

Newspaper Coverage of Miami A.M.A. Meeting

The publicity aspects of the recent Clinical Meeting of the American Medical Association held in Miami are particularly newsworthy in Florida. A check of 27 daily newspapers in scattered sections of the country to determine the impact of this meeting on the newspaper-reading public disclosed that 22 of the 27 newspapers carried 35 news articles or pictures over a four day period. This was regarded as an exceptionally high response. The 22 papers represented a circulation of more than 4,000,000. If this ratio held true for all of the 1,785 daily newspapers in the United States, 1,433, or 81.4 per cent, of them carried stories mentioning this medical meeting during the four day period.

The most popular story coming out of the Clinical Meeting was the selection of the General Practitioner of the Year. Lengthy stories on the award appeared in eight of the papers checked. Two, in fact, the Louisville Courier Journal and the Kansas City Star, published the story on page one. Many other papers carried pictures on inside pages. The A.M.A. Public Relations Department received clippings from more than 20 other newspapers not in the survey which published editorials on the recipient of the honor, explaining for what the award stands. In medicine, as elsewhere, the human interest approach never fails to have wide reader appeal.

Student American Medical Association 1955 Convention, May 6-8, 1955

Representatives from 67 medical schools in the United States will attend the Fifth Annual Convention of the Student American Medical Association at the Sherman Hotel in Chicago, May 6, 7 and 8. With an expected registration of over 1,000 medical students and interns, the convention promises to be the largest gathering in the short, but successful, history of SAMA.

A highlight of the three day meeting, which includes the official deliberations of the 67 member House of Delegates, will be the First Annual Banquet, held on Sunday, May 7. Dr. You Chan Yang, Korean ambassador to the United States, will speak on "Medicine and Diplomacy." The three national winners of the SAMA-Blue Shield Essay Contest will be announced at this dinner. A unique feature of the program on that day will be the appearance of Dr. Nicholas Dallis, creator of "Rex Morgan, M.D.," the popular newspaper feature. Dr. Dallis will present the story of his cartoon strip and introduce the artist team who draws it.

Dr. Louis J. Regan, a prominent physician-lawyer and one of the nation's foremost experts on malpractice, will headline a panel on forensic medicine Saturday afternoon, along with Irving Goldstein, Chicago attorney and leading authority on trial technic. Mr. Goldstein also will preside as judge at the moot court featuring SAMA members and representatives of the American Law Student Association.

Forty technical exhibitors, representing the drug and equipment industry, will display their products at the convention. Some lucky medical student will win a seven day all expense paid "Millionaire's Dream Vacation" to Miami Beach. In addition, several other awards will be made to members who register at the booths in the technical exhibit area.

John A. Oates Jr., of Bowman Gray School of Medicine, President of SAMA, invites all members of the medical profession who are in the Chicago vicinity during the convention to attend the meeting. SAMA is always happy to have its doctor friends see what it is doing. It promises them an excellent time as well as the chance to see their members-to-be struggle with many of medicine's vexing problems.

"The movement is a very healthy one," said Dr. J. S. Devitt of Milwaukee, advisor to the particularly active Marquette Chapter, in his report to his state society, "and the organization has exhibited by the statement of its objectives and by its performance as well that it is an asset to organized medicine. Not only is it a bulwark against the infiltration among our young doctors and medical students of some of the nefarious, subversive movements which were a serious source of concern and embarrassment to our profession not so many years back, but it will serve, I venture to predict, as an excellent incubator and training ground for our medical leaders of the future."

Postgraduate Medical Assemblies in Nassau

Facilities for lectures and clinical demonstrations are being provided at the New Bahamas General Hospital for physicians who spend their holidays in Nassau. An auditorium is available, situated in the beautiful gardens of the British Colonial Hotel next to its own private beach. Eminent medical lecturers from both sides of the Atlantic will be the guest speakers. This program, arranged by Dr. B. L. Frank of Montreal, the organizing physician, in agreement with the Chief Medical Officer of the Bahamas, offers physicians from the United States, Canada, Great Britain and other countries an opportunity for graduate study and an unforgettable holiday in the company of their colleagues in one of the world's most beautiful holiday resorts where climate and recreational facilities are unsurpassed. There is a registration fee of $50 for every doctor participating in the postgraduate assemblies. There are no other fees.

Commencing April 1, 1955, arrangements have been made for physicians and their families to stay in Nassau at the British Colonial Hotel, one of the most luxurious hotels in the Carribean, at especially reduced rates: modified American Plan, breakfast and dinner, including room. single person in one room, $14 per day; two persons in one room, $24 per day; and three persons in one room, $30 per day. Some of the leading air lines also have agreed to offer special arrangements. These generous offers covering transportation and hotel accommodations afford physicians and their families the opportunity to enjoy a unique holiday at exceptionally low cost. It is thought that most physicians will wish to stay for a period of two weeks, and accordingly group travel arrangements will be available from the beginning of April. Inquiries for further details may be directed to Dr. B. L. Frank, 1290 Pine Avenue West, Montreal Canada.

Graduate Medical Education

Cardiovascular Diseases Seminar Held

The Seminar on Cardiovascular Diseases, held on February 17 and 18 at the Duval Medical Center in Jacksonville was well received. The total registered attendance was 98. Special emphasis was placed on clinicopathologic conferences and clinical conferences. The panels were handled by the instructors in such a way that the physicians in charge were greatly impressed by this manner of teaching. Those in attendance were enthusiastic in their interest, which was manifested by the type of questions asked. The panel which closed the Seminar on Friday afternoon, scheduled to last an hour and a half, continued for an extra hour, and even then the audience was loathe to discontinue the discussion. It is most encouraging to see this type of enthusiasm at a highly specialized seminar on graduate medical education.

The faculty members were Dr. George T. Harrell Jr., Dean and Professor of Medicine, College of Medicine of the University of Florida, Gainesville; Dr. James W. Culbertson, Associate Professor of Internal Medicine, State University of Iowa College of Medicine, Iowa City, Iowa; Dr. Henry T. Bahnson, Associate Professor of Surgery, The Johns Hopkins University School of Medicine, Baltimore; and Dr. Samuel P. Martin, Associate Professor of Medicine and Bacteriology, Duke University School of Medicine, Durham, N. C.

The Seminar was sponsored by the Duval District Heart Association in cooperation with the Department of Medicine of the Graduate School of the University of Florida, the Florida State Board of Health, and the Florida Medical Association.

Seminar on Psychiatry
June 16-18

A Seminar on Psychiatry, planned for general practitioners, internists and all other nonpsychiatric specialists will be held at the George Washington Hotel in Jacksonville on Thursday, Friday and Saturday, June 16, 17 and 18, immediately preceding the Annual Graduate Short Course. The lecturers are Dr. Hans Lowenbach, Professor of Psychiatry, Duke University School of Medicine, Durham, N. C., and Dr. Leo H. Bartemeier, Director, The Seton Institute, Baltimore. Dr. Bartemeier is chairman of the Mental Health Committee of the American Medical Association. This unique opportunity for graduate training in psychiatry should have wide appeal to practicing physicians in many branches of medicine.

Twenty-Third Annual Graduate Short Course
June 20-24

The George Washington Hotel in Jacksonville will be the scene of the Twenty-Third Annual Graduate Short Course. The dates this year are June 20 through June 24. As in years past, the faculty is outstanding. and the subjects taught are of particular interest.

The lecturers and their subjects are: Medicine: Dr. Eugene A. Stead Jr., Professor of Medicine, Duke University School of Medicine, Durham, N. C.; Radiology: Dr. Herbert D. Kerman, Associate Professor of Radiology, University of Louisville School of Medicine, Louisville, Ky.; Pediatrics: Dr. Wilburt C. Davison, Dean and Professor of Pediatrics, Duke University School of Medicine, Durham, N. C.; Surgery: Dr. William F. Rienhoff Jr., Associate Professor of Surgery, The Johns Hopkins University School of Medicine, Baltimore; and Gynecology: Dr. E. C. Hamblen, Professor of Endocrinology, Duke University School of Medicine, Durham, N. C.

The Short Course is presented each year under the auspices of the Department of Medicine of the Graduate School of the University of Florida, the Florida State Board of Health and the Florida Medical Association.

Kerosene Hazard to Children
Florida Study of Accidental Poisonings

Kerosene has a prominent, and largely preventable, role as a killer of young children from accidental poisoning. A study by Katherine Bain,[1] Associate Chief of the United States Children's Bureau, indicated that petroleum products are responsible for 25 per cent of the deaths from this cause in children under 5 years of age in the United States, running a close third to materials for external use and drugs. Of petroleum products, kerosene took its highest toll among the nonwhite population of the South.

Some 400 children in this age group die each year because of accidental poisonings due to solids or liquids. The number of deaths per year in this country in 1949-1950 due to accidental poisonings was 2.6 per 100,000 population, or four times that of Great Britain. The rate in 13 southern states varied between 3 and 6.2 per 100,000 for these two years, with Mississippi having the highest rate.[1] Florida's rate was 4.2. The prominent role of kerosene in this high rate in the South was one factor which accounted for the increased over-all United States rate in comparison with that of Britain, and also for the apparently less important role of drug poisoning in the United States.

In Florida, a study of the kerosene hazard to young children was reported by Dr. Hugh A. Carithers of Jacksonville at the recent Miami Clinical Meeting of the American Medical Association.[2] In an effort to determine the incidence of poisonings within the state caused by ingestion of volatile oils, a questionnaire was sent to 156 hospitals by the Florida Childrens Commission in cooperation with the Florida Chapter of The American Academy of Pediatrics and The Florida Pediatric Society. Replies from 90 hospitals disclosed that in 1953 there were 229 children under 6 years of age admitted to 45 hospitals for treatment because of poisoning by volatile oils. Nearly all of these children drank kerosene. In addition, 78 children were treated as outpatients in 18 hospitals, and reports from 24 hospitals indicated that 288 others probably were treated. Nearly 600 Florida children, therefore, were treated in that one year for poisoning by volatile oils, caused in almost all cases by the ingestion of kerosene. While there was only 1 fatality in this group, 4 other children, not treated in the reporting hospitals, met death in the state in 1953 from drinking petroleum products. These fatalities point to a higher incidence of this type of poisoning than the replies to the questionnaire indicated.

At one of the reporting hospitals, The Duval Medical Center in Jacksonville, 76 patients were treated on the charity childrens' service, 1 of whom died. The mean hospital stay of these children was 4.53 days. On the basis of this average period of hospitalization and the per diem cost of $12.36 in this hospital during 1953, the cost of hospitalizing the known 229 patients treated in Florida hospitals that year mounted to approximately $12,800. The cost in terms of crippling effect and of psychological trauma to the young child and his parents, however, cannot be calculated.

Carithers observed that a decided seasonal incidence naturally would be expected in the Jacksonville area where kerosene is widely used for heating homes as well as for cooking, but investigation disclosed a fairly equal distribution of cases year after year. He explained the numerous cases in the wards during the summer on the basis that although there may be more kerosene in the environment in the winter, the child is more likely to drink it in the summer because of thirst. This observation led him to emphasize an important principle in the prevention among young children of poisoning from all toxic liquids, namely, that runabouts should be given fluids between meals, especially in hot weather, so that thirst will not be the stimulus to the consumption of liquid poison.

Easy access to poisonous substances is doubtless the basic reason for the frequency of accidental poisonings in young children. The figures indicate carelessness or complacency that cannot be condoned. The chance of kerosene poisoning is increased by the practice of keeping this substance in a soft drink bottle.[3] Bain was of the opinion that "roughly two thirds of the deaths from accidental poisoning could be wiped out if aspirin, barbiturates, kerosene, lye, lead, and arsenic were unavailable to small children." The magnitude of the problem, which far exceeds that of poliomyelitis, becomes apparent when one considers that for each child who dies from this cause, a large number recover, many of whom are left crippled by lead encephalitis, liver or kidney damage, and cicatricial closure of the esophagus.[3] It has been estimated that for every fatal accident in this age group, there are at

least 100 nonfatal accidents, 4 of which result in some permanent disability.[2]

The physician's responsibility in coping with this problem is clear. He has many opportunities to warn and suggest, as Carithers pointed out, and to have a leading part in the cooperative efforts now being brought to bear to improve the record of the individual states and the country as a whole in this matter.

1. Bain, K.: Deaths Due to Accidental Poisoning in Young Children, J. Pediat. 44:616-623 (June) 1954.
2. Carithers, H. A.: Accident Prevention in Childhood, The Kerosene Hazard. Read before the Section on Pediatrics at the Eighth Clinical Meeting of the American Medical Association, Miami, Dec. 1, 1954.
3. Poisoning in Children, J.A.M.A. 157:347 (Jan. 22) 1955; Kerosene Poisoning, ibid. 157:448-449 (Jan. 29) 1955.

Lye Poisoning in Young Children: Florida Control Legislation Pattern For Other Protection

The passage of a national law on March 4, 1927 requiring the labeling of containers of lye and similar corrosives as "Poison" has been credited with lowering materially in young children the incidence of burns of the esophagus, with their resultant tragic scarring and atresia. This law is a milestone in the campaign for accident prevention among young children. Publicity relative to the passage of the act was, no doubt, a factor in education of the public in the danger of consumption of lye and helped to lower the incidence of death and crippling from this cause. Behind the passage of the act was considerable altruistic activity by physicians, who encountered opposition from manufacturers, jobbers and distributors. Lye was sold under literally scores of labels at the time of the passage of the law, and it was believed by many that, even if a labeling law were passed, it could not be enforced.

Chevalier Jackson,[1] the father of bronchoscopy, in his chairman's address before the Section of Laryngology and Otology of the American Medical Association in 1910, dramatically pointed out the desirability for legislation requiring the labeling of lye and similar corrosives as "Poison." The large number of young children, of whom four had been seen by him in recent months, dying from malnutrition because of the inability to eat following stricture of the esophagus after ingestion of lye, disturbed him profoundly.

Subsequent to the delivery of Jackson's paper, a Committee on Lye Legislation of the Section on Laryngology, Otology and Rhinology of the American Medical Association was appointed. In a section meeting in 1922, the committee reported the finding of 490 cases of lye poisoning as a result of a questionnaire sent to 1,448 esophagoscopists and surgeons.[2]

The Commonwealth of Pennsylvania, through the efforts of Jackson and other physicians, passed a lye labeling law in 1923. Florida, in the same year, became the second state to pass a lye labeling act. To quote from the 1923 report of the Committee on Lye Legislation:[3] "Dr. H. M. Taylor, of Jacksonville, Florida, reports that, as a result of his presenting the clinical and other facts in evidence of the necessity for protective legislation, the legislature of Florida promptly, by an almost unanimous vote, passed a bill modeled after the Pennsylvania statute, providing for proper labeling of lye. The prompt action by the legislators and governors of Pennsylvania and Florida shows the unanimity of legislatively trained minds as to the necessity of legislation, just as soon as the facts in the case were brought to their attention."

Dr. Taylor,[4] accompanied by Dr. Ralph N. Greene, had visited the legislature and presented "the crying need for this legislation." Before leaving Tallahassee Dr. Taylor had a promise that a bill would be presented on May 21. The county medical societies in the state were notified of the date and they responded "nobly" with telegrams pouring in from every corner of the state from physicians, civic clubs, chambers of commerce, women's clubs and child welfare organizations.

Dr. Taylor[5] further aided the fight against lye poisoning by securing the endorsement of the passage of the Florida bill by Mr. J. H. McLaurin, at that time president of the American Wholesale Grocers' Association, and of Hon. Cary A. Hardee, then Governor of the State of Florida. These endorsements were valuable when the national law was being considered.

It was apparent that there was a great reduction in the number of cases of lye poisoning after the passage of the lye labeling law, according to Dr. Taylor. Jackson and Jackson[6] stated that an adequate "Poison" label probably accounted for 90 per cent of the reduction in this type of poisoning.

The two most common types of poisoning encountered by Florida children today are caused by the ingestion of aspirin and the consumption of kerosene. Would it not be of value to require by law that dispensers of all flavored aspirin dis-

play a relatively large warning label on all packages of this product? Would it not also save the lives of Florida children to require by law the labeling of all small containers, of under 11 gallons, containing kerosene or related oils, sold filled, or brought to a source and filled, or partially filled, with these products as "Poison When Taken Internally"?

Hugh A. Carithers

1. Jackson, C: Esophageal Stenosis Following Swallowing of Caustic Alkalis, J. A. M. A. 55:1857-1858 (Nov. 26) 1910.
2. Report of Committee on Lye Legislation Section of Laryngology, Otology and Rhinology, J. A. M. A. 79:1843 (Nov. 25) 1922.
3. Report of Committee on Lye Legislation Section on Laryngology, Otology and Rhinology, J. A. M. A. 81:2033 (Dec. 15) 1923.
4. Taylor, H. M.: Lye Legislation in Florida, J. Florida M. A. 10:126-131 (Nov.) 1923.
5. Taylor, M.: Experience in Medical Legislation, Laryngoscope 34:826-830 (Oct.) 1924.
6. Jackson, Chevalier, and Jackson, Chevalier L., editors: Diseases of Nose, Throat, and Ear, Including Bronchoscopy and Esophagoscopy, Philadelphia. W. B. Saunders Company, 1945.

OTHERS ARE SAYING

A Geriatrics Clinic in a Home for the Aged

The value of medical clinics, such as cardiac, mental hygiene, well-babies, and cancer clinics, has been proved through decades of service to humanity. The majority of patients attending clinics in the outpatient department of hospitals are mature adults, with many over the age of 60. Clinics especially planned for the care of aged patients are therefore justified by the large number of people that they would serve. Such a clinic could be associated with general hospitals as an integral part of the outpatient department. Or, as an activity of a progressive home for the aged, it could offer not only a well-equipped and staffed infirmary to care for sick residents, and affiliation with a general hospital for treatment of the more acute medical and surgical illnesses.

The advantages of early diagnosis and treatment have been widely publicized, and, consequently, more and more people are seeking physicians and clinics rendering such services even though at the time they may be free of any symptoms of disease.

A geriatrics clinic would devote its efforts to maintenance of optimal mental and physical health, and would provide a source of needed information on the early stages of many chronic diseases. Old people should remain in their own homes as long as possible, and institutional life, no matter how attractive it is made, should be postponed until it is inevitable. Ambulatory persons need periodic check-ups to ward off recurrences of illness and to retard onset of degenerative diseases. In this group are people with heart disease, diabetes, hypertension, arthritis, anemias, and also many patients with neuroses and mild psychoses who could be cared for outside of institutions. In addition, instruction would be given in such matters as nutrition, hygiene, occupations, retirement, and exercise.

A modern geriatrics clinic would be incomplete without a department for physical and social rehabilitation. Here again there is need for physicians with wide experience in geriatrics problems.

Some of the important functions of such a geriatrics clinic would be in relation to the residents of the home:

1. Medical care, including preventive geriatrics, of the residents would entail routine check-ups and follow-ups, and also treatment of minor illnesses not requiring confinement in the infirmary.

2. Preadmission examination of each applicant would be made by a member of the medical staff to evaluate physical status and to ascertain if the home has adequate facilities for his care. Following the necessary laboratory ex-

Louis L. Amato, a graduate of New York University College of Medicine in 1937, is medical director of the Francis Schervier Home and Hospital, New York City.
Editor's Note: Dr. Amato is now engaged in practice in Fort Lauderdale.

aminations, the doctor would evaluate physical capacity and occupational aptitude of the applicant according to the scheme outlined by Dr. Zeman.[1] This rating would be of value to the social worker, physiotherapist, and administrative personnel. The social worker would interview the applicant, eliciting data on personal life, family, occupations, interests, problems, and financial status, and submit a confidential report to the admissions committee.

3. Applicants on the waiting list would attend the clinic at regular intervals until admitted to the home. Active participation in the home's functions would acquaint the applicant with the home and its activities, and indoctrinate him in the value of periodic medical supervision and preventive geriatrics. In this way, the transition from life in a private home to that in an institution would be gradual and less likely to result in disappointment.

Such a clinic would serve as a community geriatrics clinic, where both diagnostic and therapeutic services would be available. The comprehensive medical examination would include a thorough medical, social and occupational history, and an evaluation of habits and psychological patterns. Various questionnaires would be filled out touching upon such matters as family, work, hobbies and habits, daily routine, and activities. Also, past medical and surgical history, present status of health and symptoms, medications, and present medical attendant would be ascertained.

On the basis of the health inventory, the physician would request certain laboratory tests, including a complete blood count, blood sugar, cholesterol, sedimentation rate, N.P.N., urinalysis, chest roentgenogram, and cardiogram. By means of examination and laboratory studies, the detection of incipient disease might be possible.

The physician would set down a program of medical care and guidance. Many of these people have some degree of physical disability and are in need of varying amounts of rehabilitation. Any treatment is incomplete without some effort at rehabilitation, which in its broadest sense includes physical, social, and economic recovery. Therefore, the services of a well-trained physiotherapist, occupational therapist, and social worker are essential.

A geriatrics clinic would also serve as a community counseling center, offering psychological guidance, and assisting older people in such matters as retirement, employment, housing, and recreation. The social worker and a psychologist or psychiatrist would be indispensable in this phase of service. The physician would discuss with each patient matters relating to nutrition, bodily habits, maintenance of health, and recreation, and direct interest toward wholesome activities. The counsel of an understanding chaplain would be of great value.

The general practitioner learns his pediatrics from child specialists and clinics. In like manner, we must supply geriatrics clinics and experienced medical personnel so that he will have a comparable opportunity to obtain information and training on patients at the other end of life.

Louis L. Amato, M.D.

Reference

1. Frederic D. Zeman: The functional capacity of the aged, J. Mt. Sinai Hospital 14:721-728, 1947.

—Geriatrics, April 1954

"They Don't Print Our Side!"

About a month ago, on a flight from Chicago to Washington, your Observer fell into conversation with a representative of a labor union. He related in some detail the difficulties his union had had with employers. Irked with them, he was particularly bitter toward the newspapers, whom he angrily accused of favoritism, saying, "They don't print our side!"

This had a familiar ring. How often doctors have been heard to say the same thing. The inference is that the press is unfriendly and seeks by means of unfavorable news reports to undermine public confidence in the medical profession. At the very least, they say, newspapers are prone to play up criticism and controversy to the exclusion of contributions made by the profession to the public welfare.

There is no denying that unfavorable news stories have appeared — too many of them. On the credit side, however, there have been many more that inspire confidence. This observation is based on a daily check of Washington newspapers, which devote as much or more space to medical matters as do newspapers in other metropolitan centers.

It is true that most of the so-called favorable stories are concerned with scientific aspects of medicine, those of a critical nature being largely in the political and socioeconomic field — Government versus private system of medical care, medical legislation, and various methods of paying for medical services. This should occasion no surprise,

for this has been and will continue to be a controversial area for some time to come.

As is well known, controversy is news and newspapers make the most of it. It is their business to print views on both sides and to present facts in an objective manner. To do this to the satisfaction of all concerned is, of course, impossible. On the other hand, even newspapers known for their integrity in the matter of news at times place undue emphasis on certain facets of a story which lead one to suspect where their sympathies lie. Infrequently a report is factually incorrect. On the whole there would seem to be little justifiable complaint on this score where Washington newspapers are concerned. They may not see eye to eye with the medical profession in their editorial columns but they do aim to be factual in their news columns.

If we are honest with ourselves, the situation boils down to this: We, like the union representative, are troubled when we appear in an unfavorable light, especially in the press. We have a feeling that if a newspaper was friendly it would omit what we feel is unjustified criticism and publish what we know to be the whole and true story. We are reluctant to admit, even when we know it is true, that our medical organizations make mistakes. We cannot reconcile ourselves to being involved in controversy where sometimes intemperate and unfair statements are made about us.

This is not to suggest that our position on most issues under debate is not sound, or that we should not seek a better press, but to urge that we take a more philosophic view of our relations with newspapers. Regardless of criticism in the press, if our stand on such vital matters as the health of the people is primarily in their interest it will prevail.

—*Medical Annals of the District of Columbia, October 1954*

NOTICE

Your March Journal carried a complete program and other detailed information relative to the Eighty-First Annual Meeting of the Association in St. Petersburg, April 3-6.

Medical Officers Returned

Dr. Joseph E. Thomas, who entered military service on Nov. 16, 1952, was released from active duty on Nov. 15, 1954 with the rank of captain, U.S.A.F. His address is 401 St. Francis Ave., Nashville, Tenn.

Dr. David L. Rowe, who entered military service on Jan. 1, 1953, was released from active duty on Feb. 7, 1955 with the rank of captain, U. S. Army. His address is General Delivery, Fort Pierce.

Dr. Irvin C. Schneider, who entered military service on Nov. 15, 1952, was released from active duty on Aug. 15, 1954 with the rank of lieutenant, U.S.N.R. His address is 315 Greenleaf Bldg., Jacksonville.

Dr. West B. Magnon, who entered military service on Aug. 22, 1952, was released from active duty on Nov. 30, 1953 with the rank of first lieutenant, U. S. Army. His address is 442 West Lafayette St., Tampa.

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. Theodore J. Grable of Tampa announce the birth of a daughter on Jan. 19, 1955.

Dr. and Mrs. Williard R. Gatling of Jacksonville announce the birth of a daughter, Suzanne Moore, on Feb. 12, 1955.

Marriages

Dr. Thomas L. Glennan and Mrs. Sue Murphy, both of Green Cove Springs, were married on Feb. 27, 1955.

Deaths — Members

Selling, Lowell S., Orlando.....Jan. 18, 1955
Yost, Orin R., Ormond Beach.....Jan. 23, 1955
Taylor, Gordon B., St. Petersburg.....March 15, 1955

Deaths — Other Doctors

Tuten, John K. G., McCormick, S. C.....Sept. 23, 1954
Lee, Frank C., Orlando.....Jan. 31, 1955

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Andrus, Don L., Miami

Bartlett, Robert C., Miami

Bishopric, George A., Sarasota

Butler, Fred A., Tallahassee

Chapin, J. Paul, Tallahassee

Combes, Lloyd G., Sarasota

Dickinson, Thomas G., Sarasota

Geiger, Eric F., Milton

Gibson, Robert L., Ocala

Griffin, John M., Quincy

Hatt, William S.. Sarasota

Heydrich, Alfred L., Apopka

Hutchison, William J., Tallahassee

Jordan, Harry, Trenton

Kraeft, Nelson H., Tallahassee

McCain, George H., Tallahassee

Mixson, William T. Jr., Coral Gables

Murray, Louis C., Orlando

Peterson, Wesley L. Jr., Sarasota

Price, Charles D., Winter Park

Simpson, Forbes R., Daytona Beach

Stevenson, Alan J., Tampa

Stone, Daniel L., Miami Beach

Thigpen, Frederick B., Tallahassee

Thompson, James E., Chattahoochee

Warson, Samuel R., Sarasota

Wilkison, Earl E., Tallahassee

Williams, Frank E., Century

Williams, Wade H., Englewood

Williamson, James W., Winter Park

Willis, William R., Orlando

STATE NEWS ITEMS

Dr. Louis M. Orr of Orlando was guest speaker at the January meeting of the Houston Surgical Society in Houston, Tex. His subject was "Renal Counterbalance."

Dr. Hawley H. Seiler of Tampa was one of the invited guest speakers at the Sixth Mexican Congress on Tuberculosis and Silicosis held in Mexico City during the last week in January. He presented papers on "Pulmonary Resection for Metastatic Malignancy" and "Classification and Diagnosis of Mediastinal Tumors."

Dr. C. Ashley Bird of Jacksonville attended a postgraduate course in neurology and neurosurgery, Continuation Center Study, at the University of Minnesota, February 7 through 12. He returned to his practice on February 14.

Dr. Bird gave a paper on "Treatment of Head Injuries" at the Veterans Administration Hospital, Lake City, on February 16.

Dr. Rothwell C. Polk of Jacksonville spoke on cancer at the Bishop Kenny School in that city on February 10.

Dr. Chas. J. Collins of Orlando has been elected vice president of the South Atlantic Association of Obstetricians and Gynecologists. The election took place at the meeting held February 10-12 in Williamsburg, Va.

Dr. Charles McC. Gray of Tampa has been elected to the Board of Chancellors of the American College of Radiology.

The Sixth Annual Meeting of the South Carolina Heart Association will be held on April 11 and 12, in the Baruch Auditorium in Charleston. Cosponsor of the meeting is the Charleston County Medical Society. All Florida physicians are invited to attend the scientific session, which will be held on the 12th.

Dr. George W. Karelas of Newberry has returned to his practice after attending the Venereal Disease Conference at the Tulane University of Louisiana School of Medicine in New Orleans.

Dr. Henry G. Morton of Sarasota was principal speaker at a meeting of the Florida Upper West Coast Group of Medical Records Librarians on January 20.

Dr. Frank G. Slaughter of Jacksonville was speaker at the fifth anniversary celebration of the Southside Branch Library in that city.

Dr. Elbert McLaury of Hollywood has been appointed to a four-year term as a member of the municipal library board by the Hollywood City Commission.

Dr. Vernon T. Grizzard of Jacksonville spoke at the second annual meeting of the North Florida Chapter, Multiple Sclerosis Association.

Dr. I. Sylvester Hankins of Orlando was honored by being chosen Volunteer-of-the-Week by the Volunteer Bureau of United Community Services in January.

Dr. Joseph M. Bistowish Jr. of Tallahassee was chosen "Man of the Year" for 1954 by the Tallahassee Junior Chamber of Commerce.

Dr. Wm. W. McKibben of Miami was presented the Exchange Club's "Book of Golden Deeds" on January 27. The award is presented annually to a Miami resident who has served the community in an outstanding manner for a long time.

Dr. Erasmus B. Hardee of Vero Beach was recently appointed to the Resolutions Committee of the Federated State Board of Medical Examiners of the United States. Dr. Hardee attended the annual meeting of the Board in Chicago in February.

Dr. James V. Freeman of Clearwater spoke on radium at a meeting of the Private Duty section, Florida State Nurses' Association in February.

Drs. William S. Hatt, Henry G. Morton, Samuel R. Warson and Carlyle A. Luer of Sarasota took part in a forum on medical and psychological problems sponsored by the Happiness House P.-T.A. on February 3.

Dr. Herbert L. Bryans of Pensacola was elected president of the State Board of Health for the fifteenth consecutive time during the annual meeting in Jacksonville in February.

Dr. Christian Keedy of Miami is serving as president of the newly-formed Greater Miami Society of Psychiatry and Neurology, until the first election. Dr. Paul S. Jarrett is temporary vice president, and Dr. Bruce W. Alspach, secretary-treasurer. Both of these doctors are from Miami also. Forty-two physicians specializing in neurology, neurosurgery or psychiatry are members of the new organization.

Dr. John A. Mease Jr. of Dunedin spoke on arthritis and x-ray at the meeting of the Tampa Society of X-Ray Technicians held recently in Dunedin. Dr. James F. Spindler, also of Dunedin, gave a talk on "Modern Day Concepts of Radiation."

Dr. John R. Hilsenbeck of Miami has been appointed medical chairman of the Dade County Civil Defense Council.

Dr. John H. Mickley of Hollywood was principal speaker at a meeting of the Hollywood Beach Kiwanis Club on February 8.

Dr. C. MacKenzie Brown of Tampa gave a series of lectures at meetings of the Licensed Practical Nurses Association, Division 13. Subjects of the lectures were "The Necessity of Anesthesiology," "Prevention of Anesthetic Accidents," and "Management of Pain."

Drs. Howard H. Groskloss and Emil M. Isberg of Miami and Robert J. Grayson of Miami Beach took part in a conference to prepare registered nurses as instructors in mother and baby care.

Dr. Herbert L. Bryans of Pensacola and Dr. Wilson T. Sowder of Jacksonville were among the speakers at a three day meeting of county health department directors held in Jacksonville in February.

During the meeting, Dr. Paul W. Hughes of Fort Lauderdale was named general chairman of the Florida Health Officers' Conference; Dr. Aubrey Y. Covington of Starke, general vice chairman; and Dr. J. Basil Hall of Tavares, general secretary.

Dr. William Wickman of Miami spoke on the progress being made in cancer research at a meeting of the Miami Beach Optimist Club in February.

The Department of Otolaryngology, University of Illinois College of Medicine, announces its Annual Assembly in Otolaryngology, Sept. 19-Oct. 1, 1955. This Assembly will consist of two parts. Part I will be devoted to surgical anatomy of the head and neck, fundamental principles of neck surgery and histopathology of the ear, nose and throat. Part II will be devoted entirely to lectures and panel discussion of advancements in Otolaryngology.

The Duval District Heart Association, a Chapter of the American Heart Association, will establish a Cardiovascular Fellowship to become effective on July 1, 1955 at the Duval Medical Center in Jacksonville. The minimum requirements for applicants are one year internship and two residency or the equivalent. Application forms may be obtained upon request from the office of the Duval District Heart Association, 425 West Duval St., Jacksonville.

President Duncan T. McEwan of Orlando extended greetings to the opening session of the Southeastern Allergy Association meeting held in Orlando on March 25 and 26.

Dr. Homer L. Pearson Jr. of Miami spoke on creating better professional relations between the two professions of medicine and law at the annual meeting of the Florida Bar Association held in Miami in March.

Dr. Harry Fagan Jr. of Fort Myers entered medical service with the U. S. Navy on Aug. 14, 1954, with the rank of first lieutenant.

Dr. Martin G. Gould, formerly of Miami, announces the opening of his offices at 510 Avenue A, Fort Pierce.

Dr. Robert E. Blount of Leesburg has been appointed by the health department to conduct the maternity clinic in that area.

Dr. John C. Ajac of Coral Gables spoke on cancer treatment before the Mercy Hospital Auxiliary on February 16.

Dr. Charles McD. Harris Jr. of West Palm Beach spoke on "Memories" at a meeting of District 9, Florida State Nurses Association, on February 17.

Dr. William F. Humphreys Jr. of Panama City took part in a discussion on cerebral palsy sponsored by the local United Cerebral Palsy organization.

Dr. Chester L. Nayfield of Lakeland was principal speaker at the meeting of the Pilot Club of Lakeland held on February 17.

Dr. David Kirsh of Miami has been elected president of the Greater Miami Radiological Society, and Dr. Andre S. Capi of Hollywood has been chosen secretary-treasurer.

The Committee on Medical Motion Pictures of the A.M.A. announces that Booklet # 6 of Reviews of Medical Motion Pictures is now ready for distribution. A copy has been sent to the secretary of each state medical society and they are available to county medical societies from the Committee on Medical Motion Pictures. The price of individual booklets is 25 cents each or the complete set of six booklets including all reviews published since 1946 is available for $1.00.

Dr. Thomas N. Ryon of Miami presented a paper on medico-legal problems in a court of law at the quarterly meeting of the Dade County Chapter of the American Academy of General Practice on January 30.

Dr. Chester Cassel of Miami spoke at the regular monthly meeting of the Miami Society of X-Ray Technicians. His subject was "Roentgen Aspects of the GI Tract."

Dr. Ashbel C. Williams of Jacksonville was guest speaker at a meeting of the Woman's Auxiliary of St. Mark's Epescopal Church on March 7. His subject was "Cancer."

Dr. Lauren M. Sompayrac of Jacksonville has returned to his practice after attending the New Orleans Graduate Medical Assembly held in that city.

Dr. Sompayrac and Dr. Louis C. Skinner Jr. of Coral Gables attended the Louisiana State Dermatology Meeting also held in New Orleans.

Dr. Homer L. Pearson Jr. of Miami spoke before the Kiwanis Club of Valdosta, Ga., at a luncheon meeting on March 11.

Dr. Robert C. Welsh of Miami has returned to his practice after attending a one week symposium on strabismus sponsored by the New Orleans Academy of Ophthalmology.

Dr. E. Sterling Nichol of Miami spoke on "The Problem of Coronary Thrombosis" and Dr. Robert J. Boucek of North Miami Beach, on "The Treatment and Diagnostic Advances in High Blood Pressure," at meetings for the public sponsored by the Miami Heart Institute in March.

NOTICE

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WANTED — FOR SALE

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

OFFICE: Out-of-state dentist wishes office space in small medical building or clinic in coastal city. Must be available before October. Write 69-149, P.O. Box 1018, Jacksonville, Fla.

INTERNIST: Certified, F.A.C.P. seeks association or position with individual, group or institution full or part-time. Write 69-150, P.O. Box 1018, Jacksonville, Fla.

GENERAL SURGEON: FACS, Board certified, Florida native, 36, with family, desires position in group or with surgeon. Leaving military service in April. Write 69-151, P.O. Box 1018, Jacksonville, Fla.

DOCTOR'S OFFICE: Complete office available for Specialist or General Practitioner. Inquire at 600 S. W. 12th Ave., Miami, Fla.

COMPONENT SOCIETY NOTES

Broward

Dr. Edward Jelks of Jacksonville, Public Relations Liaison, Board of Governors, met with the public relations committee of the Broward County Medical Society in Fort Lauderdale on March 2.

Dade

At the regular meeting of the Dade County Medical Association on March 1, Dr. Elwyn G. Neal spoke on "Rehabilitation of the Child and Adult."

DeSoto-Hardee-Highlands-Glades

The regular meeting of the DeSoto-Hardee-Highlands-Glades County Medical Society was held in Wauchula on March 1. Guest speaker was Dr. C. Frank Chunn of Tampa who spoke on surgical treatment of carcinoma of the esophagus.

Jackson-Calhoun

The Jackson-Calhoun County Medical Society has paid 100 per cent of its state dues for 1955.

Lake

The Lake County Medical Society recently delivered 104 medical books to the University of Florida School of Medicine.

Dr. Robert E. Blount of Leesburg was guest speaker at the February meeting. His subject was "Total Hysterectomy."

Marion

The Marion County Medical Society met on February 15 for dinner served by the Woman's Auxiliary to raise money for furnishings for the new part of a local hospital.

Monroe

Dr. Edward Jelks of Jacksonville was guest speaker at the monthly meeting of the Monroe County Medical Society on March 3 in Key West. His subject was "Public Relations."

Nassau

The Nassau County Medical Society has paid 100 per cent of its state dues for 1955.

Pinellas

The regular monthly meeting of the Pinellas County Medical Society was held on March 7 at the Lakewood Country Club. Guest speaker was Dr. John Allen, Acting President of the University of Florida, who spoke about the University.

Polk

Dr. Homer L. Pearson Jr. of Miami spoke on "Medical Ethics" at a meeting of the Polk County Medical Association in Haines City on March 9.

Putnam

The regular meeting of the Putnam County Medical Society was held on February 8. Guest speaker was Dr. Carl M. Herbert Jr. of Gainesville who spoke on "Ovarian Tumors."

Seminole

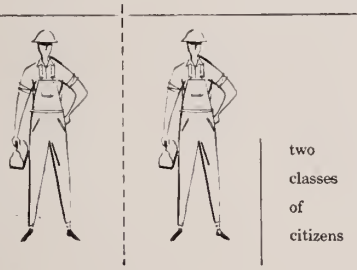
The Seminole County Medical Society has paid 100 per cent of its state dues for 1955.

Volusia

The regular monthly meeting of the Volusia County Medical Society was held on February 8. Guest speaker was Dr. Frederick H. Bowen of Jacksonville who spoke on the current issues concerning veterans non-service-connected disabilities treated by the Veterans Administration.

In Viewing the VA Medical Program . . .

effects of present veterans medical legislation



It is the belief of the medical profession that it is unsound to authorize free lifetime medical care for veterans who suffered no mishap in uniform, while other citizens with no military background must pay their own way. Although the two men above are identical, they represent "two classes of citizens"—the veteran with no service-connected disability who is granted medical care at federal expense, and the non-veteran who must personally assume responsibility for his medical care.

OBITUARIES

Joseph Feldman

Dr. Joseph Feldman of Palm Beach died Oct. 7, 1954 in that city. He was 63 years of age.

Dr. Feldman was born Aug. 25, 1891, and received his academic education at American University, Beruit, Syria. He was graduated from Long Island College of Medicine, Brooklyn, N. Y., in 1918, and after interning at the Long Island College Hospital, completed a residency at Bellevue Hospital in New York in 1920. Later he engaged in postgraduate studies abroad, at the University of Vienna and Allgemeine Poliklinic in Vienna in 1932 and the following year in Berlin, where he had special training in intranasal and plastic surgery under Professors Max Halle and Erich Ruttin. In 1939 he continued graduate work at Temple University School of Medicine in Philadelphia, which included courses in bronchoesophagology and gastroscopy.

A veteran of World War I, Dr. Feldman practiced for many years in Brooklyn, where he held positions as associate in the Cumberland and Beth Moses hospitals. He was licensed in Florida in 1946 and entered the practice of his specialty of otolaryngology at Palm Beach that year. Locally, he was on the staff of St. Mary's and the Good Samaritan Hospitals in West Palm Beach. He was a noted Hebrew scholar and author of "Mainonedes the Philosopher and Physician," published in 1938.

Dr. Feldman was a member of the Palm Beach County Medical Society and for nine years had held membership in the Florida Medical Association. He also was a member of the American Medical Association, the Kings County (N. Y.) Medical Association, the American Academy of Ophthalmology and Otolaryngology and the Florida Allergy Society. He was a diplomate of the American Board of Otolaryngology.

Surviving are the widow, Mrs. Sadie Feldman, and two daughters, Miss Gloria Feldman and Mrs. Wilfred Gordon Canada, all of Palm Beach, and one son, Dr. E. J. Feldman of the Mayo Clinic, Rochester, Minn.

James Carney Hardman

Dr. James Carney Hardman died at his home in Miami on Nov. 27, 1954. He was 60 years of age. Services on November 29 were followed by cremation.

Dr. Hardman was the son of the late Dr. and Mrs. Samuel M. Hardman of Clarksburg, W. Va., both of whom were members of families that settled in that section before the American Revolution. He attended Oberlin College and continued his premedical studies at the Johns Hopkins University. He received his medical training at the St. Louis University School of Medicine, where he was graduated in 1923. After serving an internship at St. Luke's Hospital in St. Louis, he completed a residency at Koch Memorial Tuberculosis Hospital in that city. Later he engaged in graduate study at Georgetown University School of Medicine and George Washington University School of Medicine in Washington. His fraternity was Nu Sigma Nu. He was active in sports, principally tennis.

During World War I, Dr. Hardman served four years in the United States Navy and in World War II he was sent by the War Manpower Commission to relieve physicians in war industries in various parts of the country. He practiced medicine in Huntington, W. Va., for 15 years. He came to Miami in 1946 from Washington and engaged in the general practice of medicine in Miami for eight years.

Dr. Hardman was a member of the Dade County Medical Association and of the Florida Medical Association. He also held membership in the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow, Mrs. Ruth O. Hardman, of Miami, and one sister, Mrs. James A. Chambers, of Huntington.

Thomas Henry Stokes

Dr. Thomas Henry Stokes of Pensacola died at Sacred Heart Hospital in that city on August 8, 1954 after a short illness. He was 65 years of age.

A native Floridian, Dr. Stokes was born and reared in Pensacola. He received his medical training in Georgia, where he was graduated in 1912 from the Atlanta College of Physicians and Surgeons, later Emory University School of Medicine. That same year he was licensed to practice in Florida. He located in his home city of Pensacola and engaged in the general practice of medicine there for 42 years.

Dr. Stokes was a member of the Escambia County Medical Society. He became a member of the Florida Medical Association in 1916, holding membership for 38 years. For three years he had been a life member. He was also a member of the American Medical Association.

Surviving are the widow, Mrs. Lorraine Stokes, and one son, T. H. Stokes Jr., both of Pensacola; and one brother, Clarence J. Stokes, of Sarasota.

Hamilton Biggam Frobisher

Dr. Hamilton Biggam Frobisher, formerly of Coral Gables, died at his home in Tuscon, Ariz., on Nov. 10, 1954. He was 62 years of age.

A direct descendant of Sir Hamilton Frobisher, an outstanding officer in the English Navy, Dr. Frobisher was born in New York City in 1892. Upon completion of his academic training he entered Tulane University of Louisiana School of Medicine. He was awarded the degree of Doctor of Medicine by that institution in 1921. After engaging in the general practice of medicine for 10 years, he took further hospital training and served a residency at Jackson Memorial Hospital in 1931. He then practiced internal medicine in Coral Gables until World War II. Enlisting in the Navy, he served in a base hospital in England as a lieutenant.

In 1945 Dr. Frobisher suffered a coronary attack and was discharged from military service as a result of this disability. Unable to continue in his profession, he retired and with his wife went to Tuscon to live.

Dr. Frobisher was a privileged member of the Dade County Medical Association. For 20 years he held membership in the Florida Medical Association, having honorary status the last four years. He was also a member of the American Medical Association.

Lewis William Glatzau

Dr. Lewis William Glatzau of Daytona Beach died at Halifax District Hospital in that city on Dec. 14, 1954. He was 65 years of age. Interment took place in Arlington National Cemetery, Arlington, Va.

Born at Meadville, Pa., on Oct. 1, 1888, Dr. Glatzau received his early education in his native state, attending high school at Greenville and later attending Thiel College in Grove City for undergraduate work. He was awarded the degree of Doctor of Medicine by the University of Maryland School of Medicine and College of Physicians

(Continued on page 876)

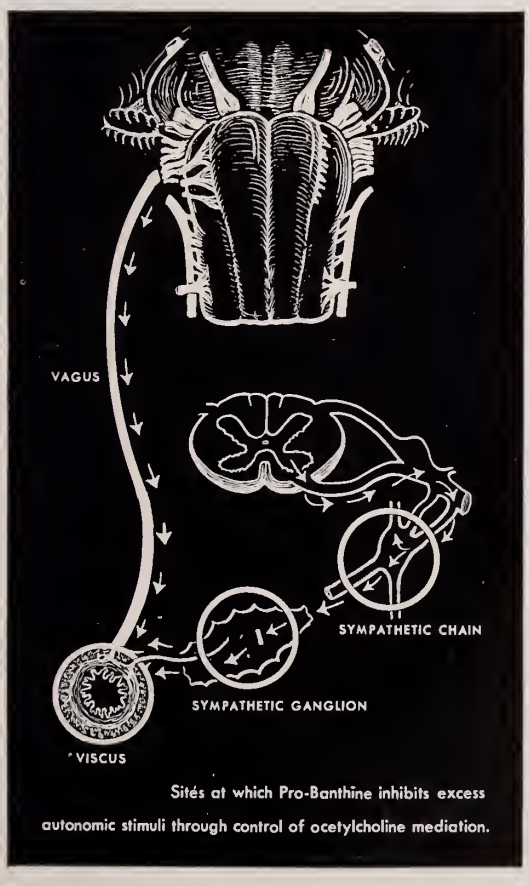
PRO-BANTHĪNE® FOR ANTICHOLINERGIC ACTION

A Combined Neuro-Effector and Ganglion Inhibitor

Pro-Banthīne consistently controls gastrointestinal hypermotility and spasm and the attendant symptoms.

Pro-Banthine is an improved anticholinergic compound. Its unique pharmacologic properties are a decided advance in the control of the most common symptoms of smooth muscle spasm in all segments of the gastrointestinal tract.

By controlling excess motility of the gastrointestinal tract, Pro-Banthine has found wide use[1] in the treatment of peptic ulcer, functional diarrheas, regional enteritis and ulcerative colitis. It is also valuable in the treatment of pylorospasm and spasm of the sphincter of Oddi.



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For the average patient one tablet of Pro-Banthine (15 mg.) with each meal and two tablets (30 mg.) at bedtime will be adequate. G. D. Searle & Co., Research in the Service of Medicine.

---

1. Schwartz I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: Gastroenterology *25*:416 (Nov.) 1953.

2. Roback, R. A., and Beal, J. M.: Gastroenterology *25*:24 (Sept.) 1953.

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(Continued from page 874)

and Surgeons in 1916. Following an internship at South Side Hospital in Pittsburgh, Pa., he served in the Medical Corps of the United States Army from 1917 to 1919. He then spent two and a half years in Austria at the University of Vienna, and upon his return to this country specialized in ophthalmology and otolaryngology.

Dr. Glatzau was licensed to practice medicine in Pennsylvania, Texas and North Carolina, and since 1916 had been licensed in Florida. He entered the practice of his specialty in Pittsburgh. Later he came to Florida, practicing first at Oldsmar and then in DeLand from 1924 until he located in Daytona Beach in 1933. Locally, he was a member of the American Legion, the Forty and Eight, Halifax Lodge 81 of F&AM, Eastern Star and the Shrine. He was a past president of the staff of Halifax District Hosital.

A member of the Volusia County Medical Society, of which he was a past president, Dr. Glatzau had held membership in the Florida Medical Association for 30 years, having honorary status the last year. He was a member of the American Medical Association and of the Florida Society of Ophthalmology and Otolaryngology.

The widow, Mrs. Winnifred A. Glatzau, survives. Also surviving are one daughter, Mrs. Helen Justice, of San Francisco; four brothers, Walter Glatzau and Edwin Glatzau, of DeLand. Carl Glatzau, of Clearwater, and Albert Glatzau, of Los Angeles; and two grandchildren.

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BOOKS RECEIVED

History of Early Medicine — History of Early Public Schools — History of Early Agricultural Relations in Dade County. By Dr. John G. DuPuis. Pp. 345. Price, $4.50. Miami, Franklin Press, 1954.

Presented in three sections, this book deals with the early medical, educational and agricultural developments in Dade County as viewed and participated in by the author, a pioneer Miami physician. Nearly half of the book is devoted to the history of early medicine and is dedicated to the memory of the charter members of the Dade County Medical Association, of which only Dr. DuPuis remains, and to the pioneer doctors of that section of Florida. A charter member and one of the founders of this society, the author also served as its president in 1906. He lists all of the pioneer physicians up to about 1915. His account is especially valuable since all of the records of this organization from its founding in 1903 to 1915 were lost. It contains biographies of the six charter members besides himself, Drs. R. H. Huddleston, James M. Jackson, Peter T. Skaggs, William S. Gramling, Edwin W. Pugh and Eleanor Gault Simmons, pioneer woman physician of Coconut Grove.

Dr. DuPuis has included many subjects related to the medical profession — "early hospitals, old folks homes, epidemics, State Board of Health and first laboratory, both state and local, diseases affecting the early population, medical meetings, pioneer nurses, dentists, opticians, anesthetists, drug stores, transportation." He recounts his first professional call in 1898, which included an encounter with a panther, his methods of transportation from ankle-express, bicycle, horseback, horse and buggy to his Maxwell of 1906, and other early medical and surgical experiences.

The second section of the book relates to the history of early public schools in Dade County, particularly the Dade County Agricultural High School fostered by Dr. DuPuis, and his experiences as a Trustee of Special School Tax District No. 3 for more than 30 years. The third section includes some of his memoirs and articles on the agricultural, economic and political situations confronting the country today, which reflect his own pioneering efforts and successes in agriculture and dairying.

The book has many interesting illustrations. It is part narrative and part a collection of related articles, communications to the author and poems. This valuable contribution to the early medical history of Florida may be obtained from bookstores or from Dr. DuPuis, 6043 N. E. Second Ave., Miami.

Planning Florida's Health Leadership. Florida's Doctors at Mid-Century. By John M. Maclachlan, Ph.D. Pp. 110. Price, $1.50. Gainesville, Fla., University of Florida Press, 1954.

This volume is the second in a series based upon the findings of research done in the course of planning for The J. Hillis Miller Health Center. The chapter headings are: Doctors in Florida; The Age Pattern of Florida's Doctors; Florida's Doctors: Supply and Need; Florida Students in Medical Schools Outside Florida; and Nonresident Florida Doctors.

This inventory of the medical profession in Florida covers such factors as the number of physicians in practice in the state and their specialties, the location of medical practitioners in the state in relation to the population, the age distribution of Florida's practitioners, the "replacement rate," and the matter of obtaining new practitioners. Consideration of replacement deals with the approximate rates of death and retirement which remove men from medical practice in the state, and the consequent rate of addition of new practitioners necessary to maintain total numbers at present levels, or to provide additional practitioners to meet the needs of a growing population. The question of obtaining new practitioners involves an examination of the rate at which new licensees have been given authority to practice in the state, the

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Bumbalo, T. S., Gustina, F. J., and Oleksiak, R. E.:
J. Pediat. 44:386, 1954.

White, R. H. R., and Standen, O. D.:
Brit. M. J. 2:755, 1953.

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Brown, H. W.:
J. Pediat. 45:419, 1954.

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rate of admission of Florida students to medical schools, and certain factors relating to the latter. These considerations provide the basis for evaluating, at least quantitatively, the present situation and the future outlook for medical practice in the State of Florida.

Planning Florida's Health Leadership. Health and the People in Florida. By John M. Maclachlan, Ph.D. Pp. 151. Price, $1.50. Gainesville, Fla., University of Florida Press, 1954.

This third volume in the Medical Center Study Series for the University of Florida tells a story of importance to all the social institutions of Florida, and especially so to the health agencies and professions. Complex and manifold are the implications for the health professions of such factors as rapid increase of the people, the concentration of growth in and around the metropolitan areas, the swift development of the smaller cities, the decline in the rural-farm population, the centrifugal pressures of suburban expansion and the increases in areas of the state hitherto underpopulated. Other related factors are rising numbers of infants and small children accompanied by an equally impressive increase in the older folk and a rising median age, as well as the declining mortality and the increasing vitality of all the people.

This study points up a trend within the state which gives Florida an opportunity to attain a position of regional, national, and even international leadership. An increasing recognition by responsible leadership of the degree to which the general welfare is based upon the general health of the people is coupled with an increased willingness of the people to face the health responsibilities the emerging new community puts upon them, and to take appropriate action. The creation of new health centers in the state, the establishment of new professional schools to meet part of the need for professional expansion, the setting up of new state-supported activities in the health fields, and the growth of a new awareness of and concern about their professional responsibilities among the health professions all attest to this change. This book should be helpful in solving many problems in health and other fields which are related to making Florida a better place in which to live.

Planning Florida's Health Leadership. Florida's Hospitals and Nurses. By John M. Maclachlan, Ph.D. Pp. 122. Price, $1.50. Gainesville, Fla., University of Florida Press, 1954.

This fourth volume in a series summarizing the findings of the Medical Center Study for the University of Florida presents selected information relating to the hospital and nursing resources of the state. Its five chapters are entitled: Hospital Facilities in Florida; Adequacy of State Hospital Resources; Special Services in Florida Hospitals; Health Team Training Facilities in Florida; and Florida's Nurses.

The various aspects of hospital operation are analyzed, and consideration is given to the present situation in this state as compared with other states in the South and with the country as a whole. Likely future needs are predicated upon the facts at hand, the rapid growth of the state and the population trends. The study includes nurses and other paramedical workers, the current supply, the future needs, and the training facilities necessary to meet future requirements. The report provides a valuable basis for future planning.

The Bane of Drug Addiction. By Orin Ross Yost, M.D. Pp. 155. Price $4.00. New York, The Macmillan Company, 1954.

This book gives an authentic account of motif and cause, symptoms and treatment of drug addiction, a challenging problem today not only to the medical, nursing, and legal professions, but also to law enforcement officers, social and welfare workers, and the general public. The drug addict is a family and a social problem.

Here, as the case histories of several of the author's former patients unfold, the reader gains insight into the complex problems that confront the addicted patient. How did he become a drug addict? What is it that made him continue to take the "junk?" How was he able to procure his daily ration of morphine, heroin, and other drugs? And, most important, why can he not stop?

The author gives a clear and in many respects encouraging report of the form of treatment that can be given successfully to a drug addict. The trend is toward a longer hospitalization with concurrent extensive psychotherapy, but less or no suffering by the patient during withdrawal therapy. The general understanding of the problem that is conveyed by this book is an essential first step toward more effective preventive measures and control of drug addiction.

Writing from his Daytona Beach home, Dr. Yost concludes the introduction to his book with this paragraph: "This book is written in the hope that the writer's 25 years of professional experience with great numbers of drug addicts may help to arouse in you, the reader—whether you are a general practitioner, professional nurse, social or welfare worker, judge, lawyer, or law-enforcement official, or just a member of the enlightened public—the interest, the knowledge, and the vigilance required to enlist your cooperation in the relentless battle against this evil. If my feelings appear strong and my recommendations harsh, it is because I have known intimately the heartbreak, the tragedy, and the catastrophe that drug addiction brings to its victims and to their hapless families."

Sports Injuries: Prevention and Active Treatment. By Christopher Woodard. Pp. 128. Price $3.00. London. Max Parrish, 1954. Sole distributor in the United States, Track & Field News, P.O. Box 296-H, Los Altos, Calif.

Active treatment is now tending to supercede the older methods of dealing with sprains and strains. In this, the first book on active treatment in sport, Dr. Woodard discusses a long list of injuries that may occur in various forms of athletic activity. These are arranged in systematic order from 'Head and Neck' to 'Knee, Ankle and Foot,' from concussion in rugger and cauliflower ears in boxing to Achilles tendon fatigue in running. Throughout, the author, who is both a doctor and an athlete, is careful to point out which types of injuries should be handled only by a doctor.

This book presents common sense views on training. To be in good training, to have supple muscles and a quick reaction time, is the best insurance against injury. For 'tuning up' the muscles, as he calls it, Dr. Woodard has devised a series of exercises by means of which not only athletes but 'even those of forty years of age or more who may not have taken any form of exercise for years' can acquire a good standard of physical strength. These exercises he had photographed specially for this book under his supervision. His remarks on allied subjects such as diet, staleness, and the ethics and efficacy of various forms of doping are also of particular interest, as is a classified list of injuries, which can be used in conjunction with the index for quick reference.

Dr. Woodard represented Cambridge University in the half-mile, and now specializes in the treatment of soft tissue injuries in athletes. He has also been honorary medical advisor to British teams at the past two Olympic Games.

Review of Medical Microbiology. By Ernest Jawetz, Ph.D., M.D. Joseph L. Melnick, Ph.D., and Edward A. Adelberg, Ph.D. Pp. 360. Price $4.50. Los Altos, Calif., Lange Medical Publications, 1954.

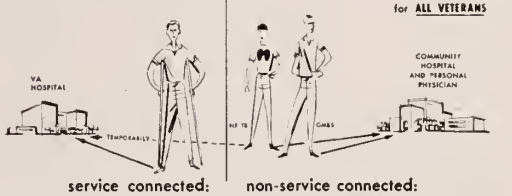
The authors' intention in preparing this Review, as stated in the preface, has been to make available a brief, accurate, up-to-date presentation of those aspects of medical microbiology which are of particular significance in the fields of clinical infections and chemotherapy. It is directed primarily at the medical student, house officer, and practicing physician. Because, however, the necessity for a clear understanding of microbiologic principles has increased in recent years as a result of important developments in biochemistry, genetics, chemotherapy, and other fields of direct medical significance, a considerable portion of this Review has been devoted to a discussion of basic science. It is to be expected that the inclusion of these sections should extend the book's usefulness to students in introductory microbiology courses as well. In general, details of technic and procedure, as well as certain materials of a controversial nature, have been excluded. Graduate students and professional microbiologists are referred to the original literature and other sources for more detailed discussions.

This book is the latest addition to a series of comprehensive texts. The publishers promise a new edition every two years and, with this in view, invite suggestions and criticisms from professional and, in particular, student readers.

In Viewing the VA Medical Program . . .

the medical profession's policy on medical care for veterans

. . . to provide the highest quality of medical care for ALL VETERANS



The medical profession stands for the highest quality medical care for all citizens. Veterans, as citizens, should accept the responsibility for their own health needs—unless they became disabled as a result of military service; then it is the responsibility of the Veterans Administration to provide medical care and hospitalization. Because many communities do not as yet have adequate facilities to care for war veterans with non-service-connected tuberculosis or neuropsychiatric disorders, the medical profession recommends that the VA continue—on a temporary basis—to treat these patients.

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Positive Health Information for the Public Our Goal Through Today's Health

The first project ever given the auxiliaries to do through the American Medical Association was to promote *Hygeia*. The *Hygeia* of yesterday has become *Today's Health*. With a new format and articles of more interest to the public and written so the public can understand them, the circulation is soaring.

The Woman's Auxiliary to the Florida Medical Association has had a great share in helping to promote positive health information and positive public relations through its continued and additional support to the promotion of this magazine which is particularly published for the public by the American Medical Association. In the year 1950-51, the Florida Auxiliary reached 500 subscriptions in Florida for the first time. Last year, 1953-54, the Florida Auxiliary reached 2,104 6/12 subscriptions for the third highest percentage in the United States. For the past two years and again this year, the Florida Auxiliary will go over its quota of participation in this project, the quota being set by the number of paid members we had in the year before. That quota for this year is 1,455 subscriptions, but we are trying hard to make 200 percent or 2,910 subscriptions.

Operation MD and DDS was started this year — an intensive drive to put *Today's Health* in every doctor's office waiting room. Spot checks throughout the U. S. have shown that at least five patients per day read and enjoy *Today's Health* in the waiting room of their doctor or dentist. Since the average doctor keeps his office open for 23 days per month, this means that the one magazine serves to help educate 115 persons every month. On a 12 month basis, one subscription serves to give some health education to 1,380 people — that is if each doctor subscribes. There are over 2,600 members of the Florida Medical Association, and if each subscribed you can easily see what a job of health education we could do through *Today's Health* in our state.

The Florida Auxiliary is more than anxious to put the magazine where it will have the most use, in doctors' and dentists' waiting rooms, in schools, in the hands of our state legislators and officials and in the hands of our federal legislators and officials. This year, as in the past, through the generosity and understanding of the need for legislators and officials to have good health information, the Florida Medical Association has ordered and paid for subscriptions for these people.

Last November, the *Today's Health* office in Chicago sent complimentary six months subscriptions to every doctor in Florida who was not a subscriber. These subscriptions expire in April and the women of the Auxiliary will be contacting all doctors for renewals and subscriptions newly made. We hope every doctor will realize the value of positive health information and public relations and will be willing to spend $1.50 of his hard

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Breathes there a doctor in Florida who to himself has not blessed out the articles in newspapers and magazines which contain misinformation that disturbs and misinforms his patients? He has a way to offset this misinformation. *Today's Health in his office waiting room* and on his mind. When a patient comes in and says, "Tell me, Doctor, I read in Reader's Digest that such and such is the new cure for so and so disease," he can aid his patient and aid our drive for factual and positive health information by telling his patient that *Today's Health* is the magazine on health that can be trusted, that every article is gone over by an editorial board who knows and that all advertising is under the seal of the American Medical Association.

There are some doctors who will tell us that they have read an article in *Today's Health* with which they don't agree. I am happy that they don't all agree on every article, for how could we be democratic and independent and have 140,000 doctors throughout the U.S. agree on everything? However, let not one article with which he doesn't agree outweigh all the things with which he does agree, which will be the majority of the articles and information in the magazine. We are appealing to all the doctors in Florida — help us go over our 200 per cent of quota but more importantly, help us promote good health information by taking *Today's Health* for your waiting room. It is a magazine of factual information for the education of your patients.

Professional rates are allowed doctors, dentists and auxiliary members. These are just one-half the price to the public. Is $1.50 per year too much to pay for educating 1,380 people per year?

Will you help us and help your patients? There is a place on every subscription blank to write in the name of the county auxiliary. Please write in the name of your medical society auxiliary and if you are in one of the rare medical societies which hasn't an auxiliary, please write in "Florida" so your state and local auxiliaries will be credited.

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Mrs. Richard F. Stover, President

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Medical Licenses Granted

Dr. Homer L. Pearson Jr., Secretary of the State Board of Medical Examiners, has reported that of the 255 applicants who took the examination of the Board, held November 22 and 23, 1954, in Jacksonville, 211 passed and have been issued licenses to practice medicine in Florida. The names and addresses of the 211 successful applicants follow:

Abbey, Joseph Ezra, Harlingen, Tex. (Beirut 1947)
Akey, Robert M., Lakeland (Kansas 1946)
Aldis, William, Camp Lejeune, N. C. (Kansas 1944)
Allen, Frederick M., New York (California 1907)
Allen, John Joseph, Winter Park (Loyola 1950)
Alley, John Clare, Miami (Rochester 1953)
Andrews, Frederick Charles, Daytona Beach (Tufts 1953)

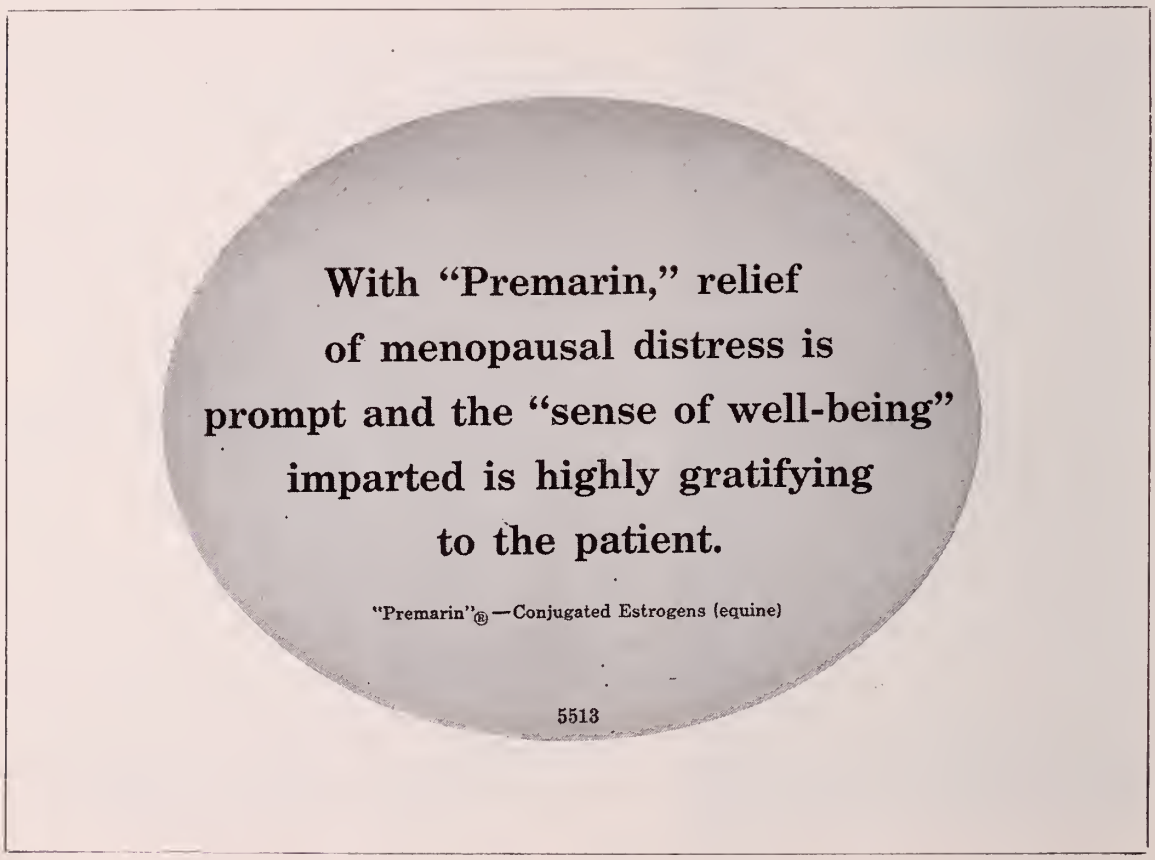
Bailey, Ralph Jordan, Ottawa, Ill. (U. Chicago 1943)
Baird, Duke Barnett, New Milford, N. J. (Alabama 1949)
Baldry, George Simpson, Reeds Ferry, N. H. (Manitoba 1941)
Bartkus, Frank A., Tampa (Pennsylvania 1953)
Bate, Doris, New York (New York 1950)
Berry, Reginald Vincent, Warrington (Yale 1932)
Betz, Richard Norman, Miami (Maryland 1954)
Blank, Orville E., Jacksonville (Tulane 1954)
Blasser, Edward F., Miami Beach (Temple 1952)
Block, Alvin Lee, Orlando (Emory 1954)
Boggus, Argin A. Jr., Fitzgerald, Ga. (Emory 1954)
Bolls, George Franklin, Lake Butler (Tennessee 1940)
Bradley, Samuel Milton, Miami (Georgetown 1954)
Brettner, Joseph C. Jr., St. Petersburg (Illinois 1950)
Brown, Roy William, Hinsdale, Ill. (Loyola 1945)
Brown, Samuel Sheppard, Brooklyn (Syracus 1923)
Buckley, Lawrence Robert, St. Petersburg (Nebraska 1950)
Budd, Merlin Bowers, Orlando (Western Reserve 1948)
Bugg, James William, New Orleans (Tulane 1954)
Burke, Edward, New Orleans (Tulane 1943)

Caldwell, William Thomas III, Miami (Columbia 1954)
Campbell, Colin, Miami (McGill 1953)
Casey, Ernest Raymond Jr., Gainesville (Geo. Wash. 1945)
Casten, Gus George, Miami (Southwestern 1948)
Chambers, Julius Burgess, Orlando (New York 1953)
Christenson, William Newcome, Palm Beach (Johns Hopkins 1948)
Church, Gaylord, Clearwater (Emory 1952)
Cohen, Allen Berman, Miami (Tulane 1954)
Cohen, Benjamin Bainis, New York (Chicago 1936)
Cohen, George Joel, Takoma Park, Md. (Geo. Wash. 1950)
Conklin, Robert Arthur, Miami (Illinois 1954)
Cooper, Henry Ramsey, Tampa (Tennessee 1943)
Coppola, Vincent Jr., Yonkers, N. Y. (Georgetown 1948)
Corwin, William, Coral Gables (Tufts 1932)
Crandall, Clarence Roger, Eau Gallie (Buffalo 1950)
Custer, Robert LaVerne, Daytona Beach (Western Reserve 1953)

Dabby, Victor, Valdosta, Ga. (Beirut 1947)
Davis, Guy Clark, Atlanta, Ga. (Oklahoma 1946)
Davis, James McCorkle, Jacksonville (Harvard 1947)
Dillard, Ruth A., Shulls Mills, N. C. (Pennsylvania 1951)
Downing, Arthur Herrmann, Des Moines, Ia. (Chicago 1939)
Dowswell, John Wallace, Jacksonville (Medical Evangelists 1954)
Drachenberg, Harry, Miami Beach (Cincinnati 1921)

Eaton, Joseph Withington, New Orleans (McGill 1935)
Engler, William, Brooklyn (Geo. Wash. 1926)
Ernst, Conrad F., Wauchula (Illinois 1953)
Estill, Robert Reeve, West Palm Beach (Nebraska 1927)

Fagan, Lewis, Miami (Chicago 1953)
Fanizzi, William John, Astoria, N. Y. (Georgetown 1948)



Farrell, John Joseph, Coral Gables (Harvard 1942)
Floyd, Marian Anita, Winter Park (Duke 1954)
Fulenwider, Robert Gignilliat, Nashville, Tenn. (Western Reserve 1952)

Galitz, Philip Jacob, Brooklyn (Maryland 1935)
Garcia, Orlando Roberto, Miami (Havana 1948)
Garner, James William, Ashburn, Ga. (Georgia 1949)
Gervais, Robert Hepworth, Orlando (New York State 1954)
Gilbert, Albert Joseph, North Canton, O. (Western Reserve 1938)
Gill, Frank E., Jacksonville (Loyola 1954)
Gillespy, Thurman Jr., Eaton, Ind. (Jefferson 1953)
Gould, Kenneth George Jr., Tampa (Duke 1954)
Greenhouse, Maxwell Nisan, Miami (Kansas City P&S 1943)
Grossberg, Sidney Edward, Durham, N. C. (Emory 1954)
Gurinsky, Abraham, Fort Knox, Ky (Havana 1948)
Gwaltney, Loral Floyd, Roachdale, Ind. (Louisville 1938)

Hagan, Andrew Daws, Jacksonville (Alabama 1954)
Hanson, Keith LaVerne, Orlando (Tennessee 1954)
Harlow, Joseph Emory, Tampa (St. Louis 1947)
Harris, Joseph, Miami Beach (Howard 1952)
Harrison, Paul Wilberforce, Penney Farms (Johns Hopkins 1908)
Heibner, Winston Churchill, St. Petersburg (Tulane 1942)
Henry, Richard Alan, Brooksville (Johns Hopkins 1953)
Herman, August Carl, Arcadia (Pennsylvania 1949)
Hicks, Dorothy J., Cleveland Heights, O. (Temple 1944)
Hicks, John Henderson, Gordo, Ala. (Alabama 1951)
Himalstein, Milton Roger, St. Petersburg (Nebraska 1934)
Hirsch, Theodore, Jacksonville (Medical Evangelists 1954)
Hodges, James Paschall, Birmingham, Ala. (Tennessee 1947)
Hooker, John Patrick, Miami (Texas 1954)
Hooker, Mildred Rose Marshall, Miami (Texas 1952)
Howell, David Sanders, Miami (Harvard 1954)
Hunter, Caroline B., Coconut Grove (Columbia 1951)
Hunter, Thomas Vanvaleah, Orlando (Albany 1954)

Imbus, Harold R., Miami (Cincinnati 1954)
Ingersoll, Charles Frederick, Fort Logan, Colo. (Indiana 1932)

Johnson, Benjamin Allen Jr., Jacksonville (Yale 1949)
Jolley, John William, Elkin, N. C. (Cincinnati 1936)
Jones, William Burrell, Ocala (Duke 1954)
Jordan, Thomas Cook, Jr., Lakeland (Georgia 1945)
Judd, Robert Charles, St. Petersburg (Medical Evangelists 1954)
Justiz, Charles T., Miami (Havana 1948)

Kartub, Jack, Miami Beach (Pittsburgh 1954)
Katrana, Nicholas John, East Moline, Ill. (Northwestern 1944)
Kearns, John Westhofen, Baltimore (Johns Hopkins 1947)
Keates, Albert Edward, San Diego, Calif. (McGill 1944)
Klein, Warren Eihle, Jacksonville (Tulane 1928)
Koehler, Robert Otto, St. Petersburg (Cincinnati 1954)
Kuder, Howard Velear, Muncie, Ind. (Georgetown 1944)

Lary, Banning Gray, Fort Lauderdale (Illinois 1948)
Laurie, Robert Edward, Miami (Jefferson 1954)
Leonard, Edward LeRoy, Chattahoochee (Oklahoma 1952)
Leonard, Paul Charles, Dunedin (Tufts 1940)
Letson, William Morton, Milton (Louisiana State 1951)
Levine, Paul, Coral Gables (Northwestern 1954)
Lewis, George N., Bartow (Tulane 1949)

Mantooth, Murray K., Jacksonville (Tennessee 1949)
Markgraf, Wolfgang Herbert, Miami (Wayne 1949)
Martinez, Gerardo Heberto, Fort McClellan, Ala. (Havana 1948)
May, Lonnie Coker Jr., Oak Ridge, Tenn. (Tennessee 1950)
McNabola, William Francis, Evanston, Ill. (Loyola 1951)
Mead, Charles Alexander Jr., Jacksonville (Geo. Wash. 1946)
Miethke, John C., Miami (Ohio State 1954)
Miller, Malcolm Elmore, Fort Lauderdale (Ohio State 1934)
Miller, Samuel Rush Jr., Fontana Dam, N. C. (Tennessee 1949)
Mitchener, James S. Jr., San Juan, Puerto Rico (Johns Hopkins 1947)
Moomaw, David Robert, Chicago (Northwestern 1948)
Morganti, Loretta Mae, Miami Beach (Pittsburgh 1954)
Moss, James Kingsley, Jacksonville (Georgia 1953)

Neumayer, Francis, Madeira Beach (Maryland 1949)
Nydell, Carl Clifford, Jacksonville (Medical Evangelists 1954)

O'Malley, Joseph Edward, New Orleans (Maryland 1950)
Onkst, Harold Ray, Miami (Ohio State 1954)
Ortega, Gimel, Fort Smith, Ark. (Mexico 1947)

Pasach, Arthur J., Miami Beach (Pittsburgh 1954)
Patry, Frederick Lorimer, Anna Maria (Toronto 1925)
Pauly, John Frederick, Miami (Geo. Wash. 1954)
Paynter, Camen Russell, Chicago (Illinois 1946)
Pedrero, Edward Jr., Jacksonville (Western Reserve 1954)
Philipp, Ernst Adolf, Chicago (Illinois 1951)
Pines, Stuart Shever, Coral Gables (New York State 1953)

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Politano, Victor Anthony, Durham, N. C. (Duke 1943)
Ponder, Billy Frank, Miami (Texas 1954)
Preston, Richard Earl, Miami (Iowa 1954)
Pryor, Thurmond Hunter, Miami (Tennessee 1954)
Puente-Duany, Guillermo Augusto, Fort McClellan, Ala. (Syracuse 1951)

Quattlebaum, Julian Killen Jr., Savannah, Ga. (Georgia 1951)

Ragona, Robert Francis, Miami (Iowa 1954)
Ramsey, John E. Jr., Atlanta, Ga. (Emory 1954)
Read, David Thurber, Miami (Columbia 1954)
Reid, Harry Gwynn Jr., South Miami (Louisville 1946)
Reid, Robert Wilson, Key West (Chicago 1941)
Rennie, Laurie Earl, Hanover, N. H. (Virginia 1954)
Rice, Marion Hobson, Atlanta, Ga. (Emory 1954)
Riemer, William E., Miami (Pennsylvania 1954)
Robinson, John Knox, Derita, N. C. (Pennsylvania 1951)
Robinson, Thomas Albert, Parchman, Miss. (Pennsylvania 1948)
Rosendorf, Stanley Bernard, Coral Gables (Geo. Wash. 1927)
Rubio, Mauricio, San Juan, Puerto Rico (Mexico 1942)
Rye, William A., West Palm Beach (Louisville 1954)

Samet, Philip, Mount Vernon, N. Y. (New York 1947)
Sander, Frank V. Jr., Detroit (Columbia 1946)
Sapp, Edwin Eugene, Jacksonville (Georgia 1953)
Schiff, Arthur Frederick, Miami (Middlesex 1943)
Schneider, Louis William, Miami (Cincinnati 1931)
Scotti, Thomas Michael, Coral Gables (Jefferson 1942)
Shaner, Harold Jack, Orlando (Tulane 1949)
Shelley, Dorothy Elizabeth, Gainesville (Kansas 1926)
Shirley, Edwin Samuel Jr. (Col.), Fort Lauderdale (Howard 1952)
Sinnett, James Monroe, Jacksonville (Temple 1948)
Slonim, Nathaniel Balfour, Pensacola (Washington 1946)
Smith, Alfred Graham II, Wauchula (Emory 1954)
Smith, Russell Conwell, Fort Washington, Pa. (Hahnemann 1930)
Smith, Samuel Frederick Jr., Lakeland (Temple 1952)
Sokolov, Joseph Louis, Coral Gables (Chicago 1951)
Solomon, Samuel, Brooklyn (Long Island 1926)
Sotolongo, Hugo Fortunato, Daytona Beach (Havana 1954)
Sporn, Hyman, Brooklyn (Long Island 1926)
Stark, Herbert Harrington, Chicago (Loyola 1951)
Stocking, Bruce W., Muncie, Ind. (Michigan 1930)
Strahan, Nathalie Alice, Miami (Cornell 1954)
Stutsman, Philip Richard, Lakeland (Marquette 1954)

Tanner, Paul Alexander Jr., Auburndale (Virginia 1953)
Tasche, John A., Sarasota (Cincinnati 1932)
Telford, Ruth Jane, Hialeah (Baylor 1950)
Tenzel, Richard Ruvin, Miami (Tennessee 1954)
Thompson, Hugh Smarr Jr., Twin City, Ga. (Emory 1952)
Trinca, Peter Joseph, Grand Rapids, Mich. (Arkansas 1940)
Trombly, Luella Rosalie, Berwyn, Ill (Loyola 1943)

Ulseth, Robert Norman, West Palm Beach (Illinois 1954)
Urbach, Stuart, Gainesville (Louisville 1947)
Uthlaut, William Winfred, Orlando (Bowman Gray 1954)

Valentine, E. Henry Jr., Macon, Ga. (Georgia 1947)
Vickery, Robert Earl, Southport (Alabama 1954)
Von Thron, Joseph Cangney, Miami (Ohio State 1954)

Waring, Nell Pape Williams, Jacksonville (Tulane 1951)
Waring, William Winburn, Jacksonville (Harvard 1947)
Werner, Harry Bernes, Bath, N. Y. (Vermont 1941)
Whitehorn, Clark Allan, Durham, N. C. (Maryland 1948)
Wilber, Harold Robinson, DeLand (Louisville 1928)
Wilcox, Robert Nelson, Jacksonville (Kansas 1954)
Wilder, J. Lloyd, Avon Park (Medical Evangelists 1953)
Williams, John Irving, Oak Park, Ill. (Minnesota 1949)
Williams, Wade Hampton, Englewood (Pennsylvania 1951)
Williams, Walter Samuel, Fort Lauderdale (Tulane 1941)
Williamson, Douglas Eugene, Sarasota (Northwestern 1953)
Williamson, Harold Lester, Tampa (Emory 1954)
Wolk, Harry Edward, Cleveland (Berlin 1933)
Wollowick, David Paul, Safety Harbor (Dalhousie 1935)
Worth, Jack Jefferson Jr., Atlanta, Ga. (Emory 1944)
Wright, Henry Livingston Jr., Tampa (Duke 1952)
Wright, John Thomas, Tampa (Vermont 1941)
Wright, Stephen Cole, Miami (Temple 1947)
Wry, Paul E., Coral Gables (Georgetown 1953)

Zasly, Louis, Coral Gables (Syracuse 1953)
Zier, Adolfo, Teaneck, N. J. (Havana 1946)



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This is only the beginning, but it gives your patient something to start with. Before long he'll want to experiment for himself. And while he's learning new flavor tricks, your treatment has a chance to show its full effectiveness.



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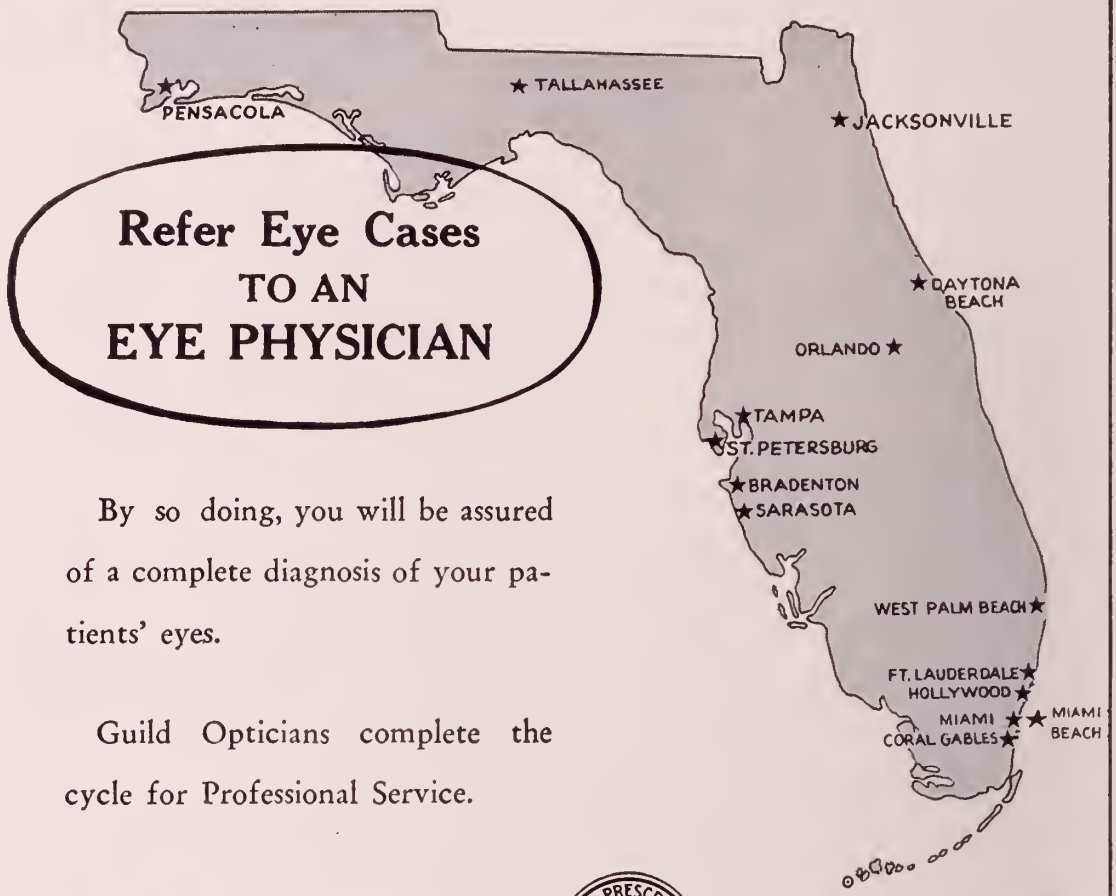
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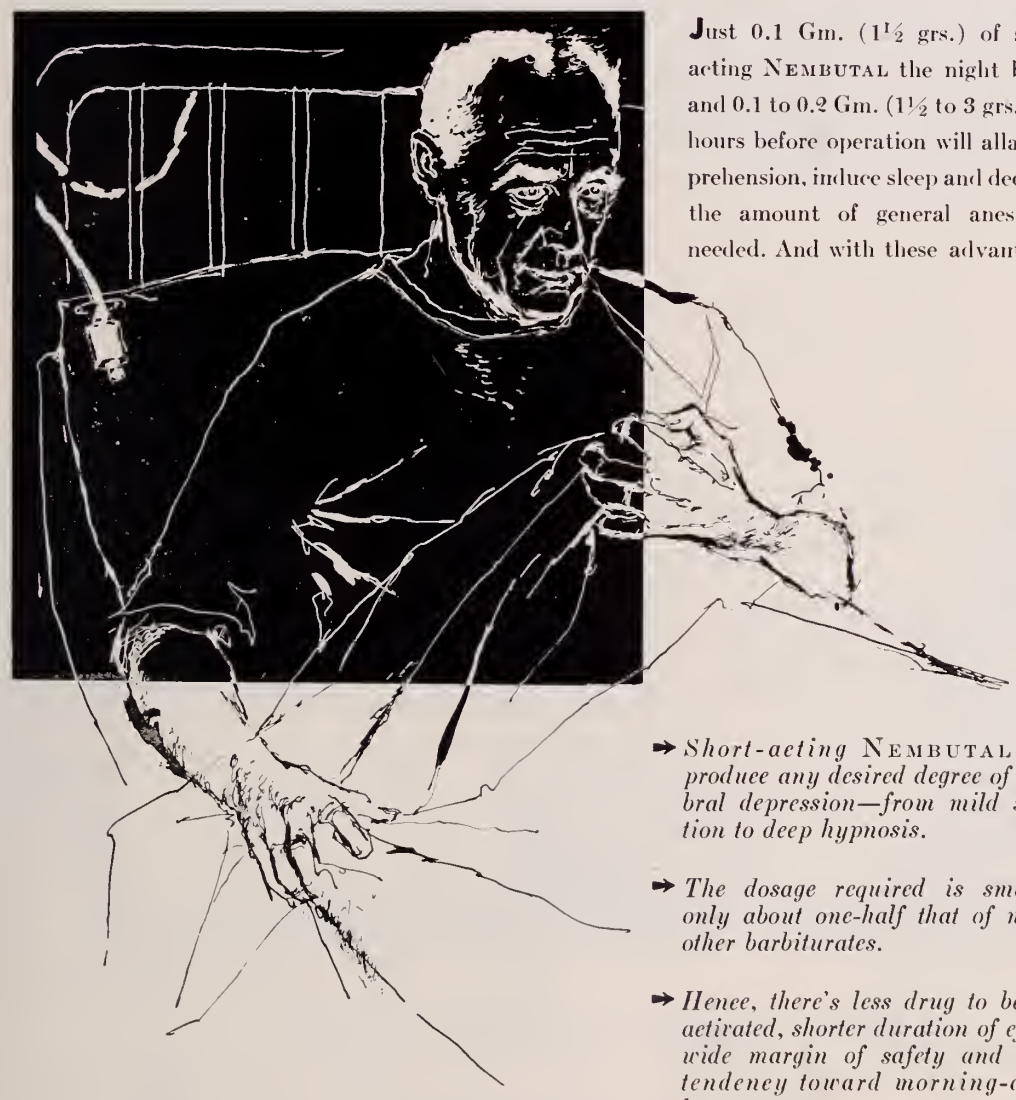
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Pensacola	Bennie Barberi	18 W. Garden St.
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Sarasota	Oscar Loewe	Main St.
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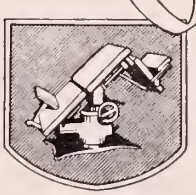
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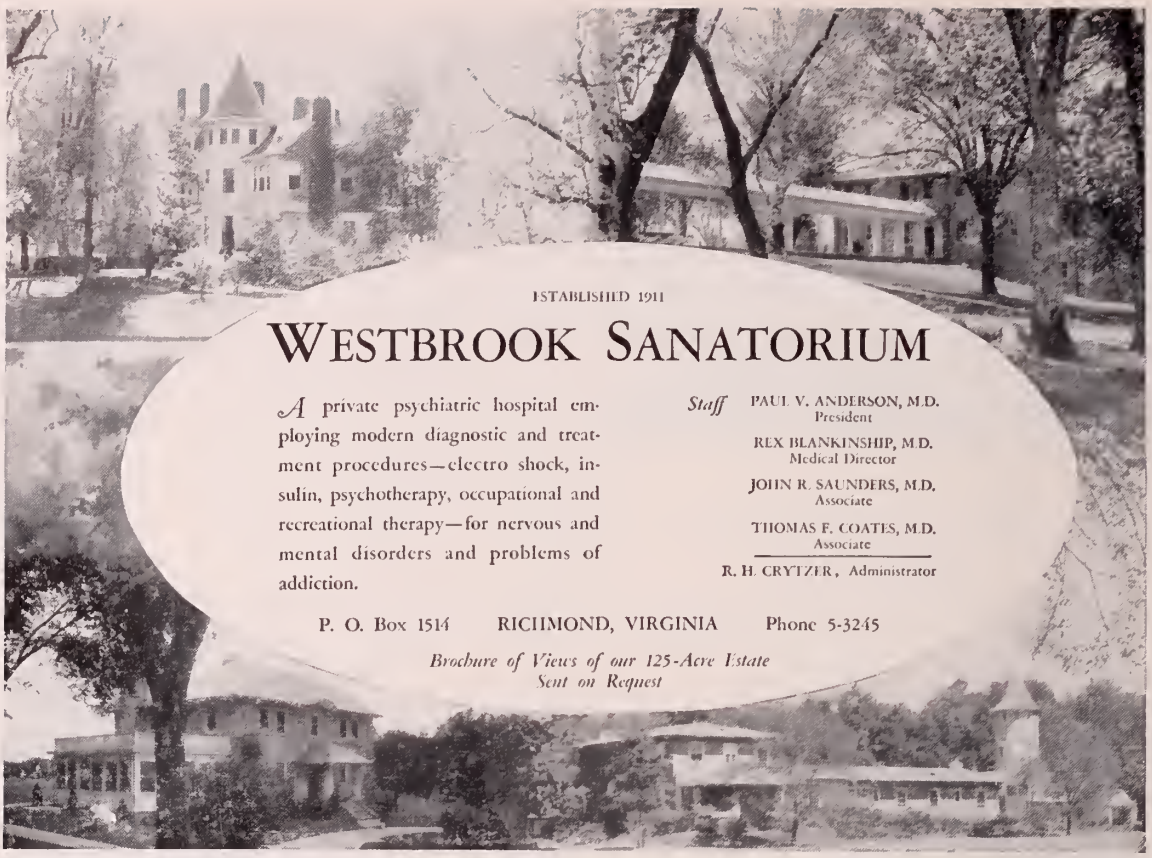
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hopedic Society	John F. Lovejoy, Jacksonville	Newton C. McCollough, Orlando	
hologists, Society of	Millard B. White, Sarasota	James B. Leonard, Clearwater	
liatric Society	Lewis T. Corum, Tampa	Joel V. McCall Jr., Daytona Beach	
ctologic Society	Claude G. Mentzer, Miami	George Williams Jr., Miami	
liological Society	A. Judson Graves, Jacksonville	James T. Shelden, Lakeland	
geons, Am. Coll., Fla. Chapter	Frederick J. Waas, Jacksonville	C. Frank Chunn, Tampa	
logical Society	Linus W. Hewit, Tampa	Frank J. Pyle, Orlando	
rida—			
asic Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, May 14, '55
lood Banks, Association	John T. Stage, Jacksonville	John B. Ross, Jacksonville	St. Petersburg, 1955
lue Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	
lue Shield of Florida, Inc.	David R. Murphey Jr., Tampa	Jack O. W. Rash, Miami	
ancer Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	
linical Diabetes Assn.	Sidney Davidson, Lake Worth	Edward R. Smith, Jacksonville	Daytona Beach, Oct. 20-21, '55
ental Society, State	Robt. Thoburn, D.D.S.,Daytona Bch	J. E. Edwards, D.D.S., Coral Gables	Jacksonville, Apr. 23-25, '55
eart Association	Alvin E. Murphy, Palm Beach	Daniel R. Usdin, Jacksonville	
ospital Association	Mr. Pat N. Groner, Pensacola	Mr. Steve F. McCrimmon, C. Gbls.	St. Petersburg, Nov. 16-18, '55
edical Examining Board	Frank D. Gray, Orlando	Homer L. Pearson Jr., Miami	
edical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, June 20-24, '55
urse Anesthetists, Fla. Assn.	Miss Dorothy Jackson, C. Gables	Mrs. Lulla F. Bryan, Miami	
urses Association, State	Martha Wolfe, R.N., Coral Gables	Agnes Anderson, R.N., Orlando	
harmaceutical Association, State	Mr. J. L. McDonald, St. Augustine	Mr. R. Q. Richards, Ft. Myers	Clearwater, May 23-25, '55
ublic Health Association	Mr. J. A. Mulrennan, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Daytona Beach, Oct. 20-22, '55
rudeau Society	Lawrence C. Manni, Tallahassee	Simon D. Doff, Jacksonville	Miami, May 12-14, '55
uberculosis & Health Assn.	Judge Ernest E. Mason, Pensacola	Mrs. W. J. Norton, Sarasota	Miami, May 12-14, '55
oman's Auxiliary	Mrs. Richard F. Stover, Miami	Mrs. S. J. Wilson, Ft. Lauderdale	
erican Medical Association	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	Atlantic City, June 6-10, '55
.M.A. Clinical Session	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	Boston, Nov. 29-Dec. 2, '55
thern Medical Association	Robt. L. Sanders, Memphis, Tenn.	Mr. V. O. Foster, Birmingham	Houston, Nov. 14-17, '55
bama Medical Association	J. M. Donald, Birmingham	Douglas L. Cannon, Montgomery	Montgomery, Apr. 21-23, '55
rgia, Medical Assn. of	Peter B. Wright, Augusta	David Henry Poer, Atlanta	Augusta, May 1-4, '55
. Hospital Conference	Mr. John W. Gill, Vicksburg, Miss.	Mr. Pat Groner, Pensacola	Atlanta, Apr. 20-22, '55
theastern Allergy Assn.	W. L. Rucks, Memphis, Tenn.	Kath. B. MacInnis, Columbia, S. C.	
theastern, Am. Urological Assn.	Sam L. Raines, Memphis, Tenn.	Robert F. Sharp, New Orleans	
theastern Surgical Congress	Donald S. Daniel, Richmond	B. T. Beasley, Atlanta	Richmond, Mar. 12-15, '56
f Coast Clinical Society	Walter C. Payne Sr., Pensacola	Barkley Beidleman, Pensacola	Pensacola, Oct. 27-28, 1955



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County Medical Societies of Florida

SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Total Members
Alachua	Edwin H. Andrews, Gainesville	Henry S. Blank, Gainesville	2nd Tues.	56
**Bradford, Gilchrist, Union*				
Bay	William F. Humphreys Jr., Panama City	Roderick C. Webb, Panama City	1st Tues.	26
Brevard	Lee Rogers Jr., Cocoa	Charles E. Russell, Cocoa	2nd Tues.	27
Broward	Ernest E. Serrano, Hollywood	Alfred E. Cronkite, Fort Lauderdale	4th Tues.	120
Columbia	Robert B. Harkness, Lake City	Thomas H. Bates, Lake City	1st Mon.	11
**Baker, Hamilton*				
Dade	L. Washington Dowlen, Miami	Robert F. Dickey, Miami	1st Tues	693
De-Soto-Hardee-Highlands-Glades	Gordon H. McSwain, Arcadia	Harold S. Agnew, Arcadia	1st Tues.	27
Duval	Raymond H. King, Jacksonville	Eugene M. Frame, Jacksonville	1st Tues.	291
**Clay*				
Escambia	George W. Morse, Pensacola	Paul F. Baranco, Pensacola	2nd Tues.	107
**Santa Rosa*				
Franklin-Gulf	Warren T. Weathington, Apalachicola	Joseph P. Hendrix, Port St. Joe	Last Wed.	7
Hillsborough	Frank S. Adamo, Tampa	Julien C. Pate Jr., Tampa	1st Tues.	184
Indian River	Kip G. Kelso, Vero Beach	Vernon L. Fromang, Vero Beach	2nd Tues.	11
Jackson-Calhoun	Henry I. Langston, Marianna	Francis M. Watson, Marianna	Quarterly	17
Lake	Louis R. Bowen, Eustis	J. Basil Hall, Tavares	1st Wed.	30
**Sumter*				
Lee-Charlotte-Collier-Hendry	Baker Whisnant, Fort Myers	James L. Bradley, Fort Myers	3rd Mon.	39
Leon-Gadsden-Liberty-Wakulla-Jefferson	William L. Hunter, Monticello	Odis G. Kendrick Jr., Tallahassee	Quarterly	68
Madison	A. Franklin Harrison, Madison	Wallace E. Winter, Madison		6
Manatee	Marjorie L. Warner, Bradenton	Harvey C. Pauley Jr., Bradenton	2nd Tues.	28
Marion	William H. Turnley, Ocala	Bertrand F. Drake, Dunnellon	3rd Tues.	30
**Levy*				
Monroe	Ralph Herz, Key West	William R. Ploss, Key West	1st Thurs.	13
Nassau	David G. Humphreys, Fernandina Beach	John W. McClane, Fernandina Beach	Last Fri.	11
Orange	Don C. Robertson, Orlando	Walter A. Derrick, Orlando	3rd Wed.	192
**Osceola*				
Palm Beach	Edwin W. Brown, West Palm Beach	James R. Anderson, West Palm Beach	4th Mon.	139
Pasco-Hernando-Citrus	Harry G. Brownlee, Zephyrhills	W. Wardlaw Jones, Dade City	2nd Thurs.	17
Pinellas	Clyde O. Anderson, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	227
Polk	Samuel J. Clark, Lakeland	Marion W. Hester, Lakeland	2nd Wed.	99
Putnam	Grover C. Collins, Palatka	Alfred P. Peretti, Palatka	2nd Tues.	10
St. Johns	George C. Hopkins, St. Augustine	Reuben J. Plant Jr., St. Augustine	3rd Tues.	21
St. Lucie-Okeechobee-Martin	Henry E. Branca, Fort Pierce	Adrian M. Sample, Fort Pierce	3rd Thurs.	22
Sarasota	Melvin M. Simmons, Sarasota	Andrew J. Jesacher, Sarasota	2nd Tues.	59
Seminole	John M. Morgan, Sanford	Terry Bird, Sanford	2nd Tues.	20
Suwannee	William P. Blackmon, Mayo	Hiram B. Curry, Jasper	1st Sat.	9
Taylor	John H. Parker Jr., Perry	Ralph J. Greene, Perry	Last Fri.	4
**Dixie, Lafayette*				
Volusia	Robert L. Miller, Daytona Beach	Achille A. Monaco, Daytona Beach	2nd Tues.	86
**Flagler*				
Walton-Okaloosa	Richard H. Lee, Crestview	Frederic E. Caldwell, Fort Walton Beach	3rd Tues	20
Washington-Holmes	L. H. Paul, Bonifay	Bayllye W. Dalton, Chipley		5
			Total	2,732

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(1) Butler, A. M., and Wolman, I. J.: Quart. Rev. Pediat. 9: 63, 1954. (2) Moore, I. H.: Journal-Lancet 74: 80, 1954. (3) Collins-Williams, C.: J. Pediat. 45: 337, 1954. (4) Clein, N. W.: Ann. Allergy 9: 195, 1951.

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History and Physical Examination
Eric E. Wollaeger

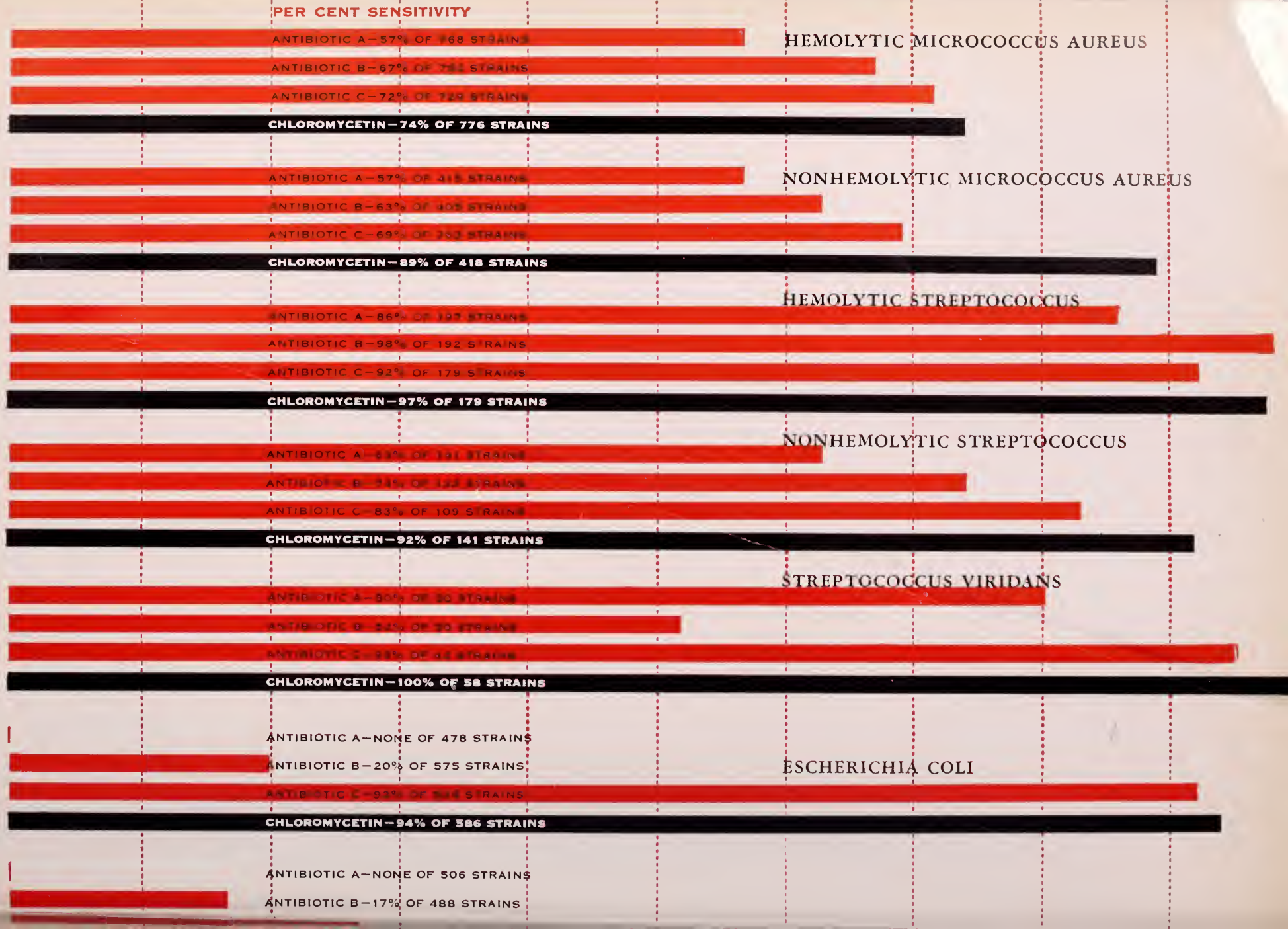
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Theodore C. Keller

Post Partal Heart Disease
Nathan L. Marcus

Management of Nasal Allergy
Bernard M. Barrett

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ANTIBIOTIC C—92% OF 179 STRAINS
CHLOROMYCETIN—97% OF 179 STRAINS
NONHEMOLYTIC STREPTOCOCCUS
ANTIBIOTIC A—83% OF 141 STRAINS
ANTIBIOTIC B—74% OF 133 STRAINS
ANTIBIOTIC C—83% OF 109 STRAINS
CHLOROMYCETIN—92% OF 141 STRAINS
STREPTOCOCCUS VIRIDANS
ANTIBIOTIC A—80% OF 30 STRAINS
ANTIBIOTIC B—52% OF 30 STRAINS
ANTIBIOTIC C—98% OF 60 STRAINS
CHLOROMYCETIN—100% OF 58 STRAINS
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ANTIBIOTIC A—NONE OF 478 STRAINS
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CHLOROMYCETIN—94% OF 586 STRAINS
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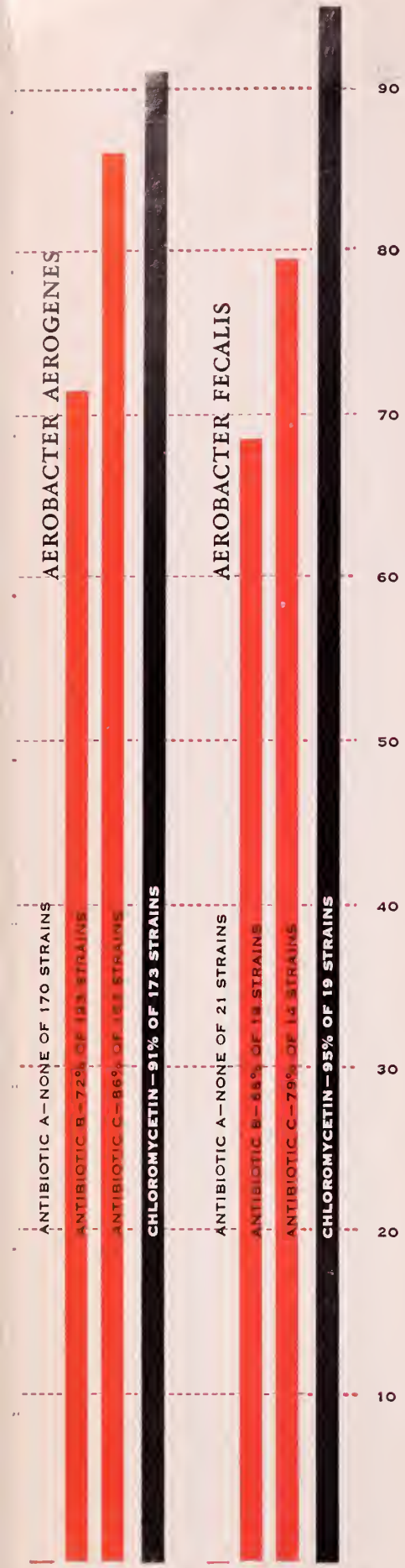
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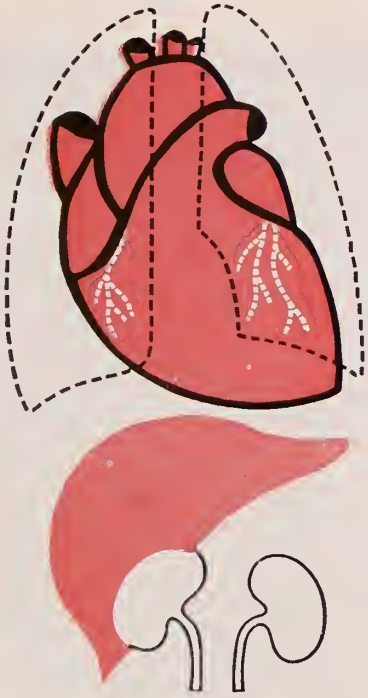
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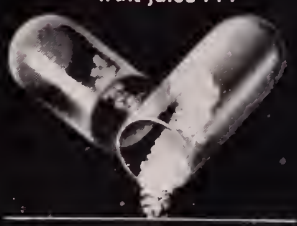


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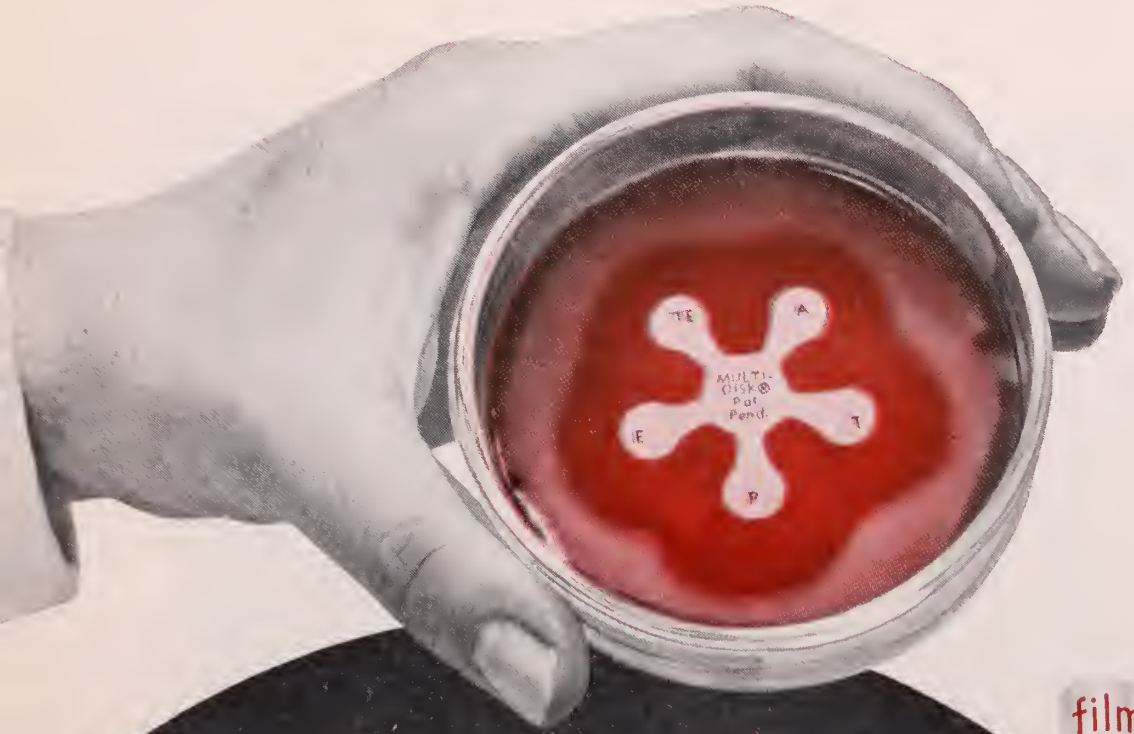
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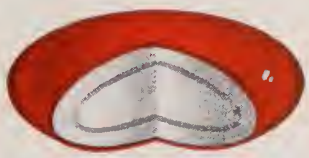
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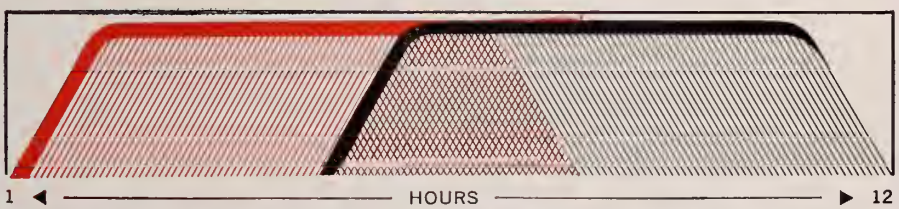
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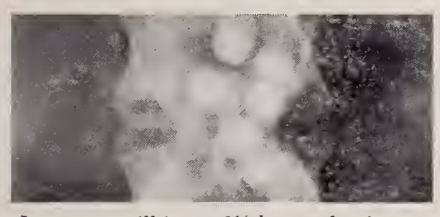
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Recent studies reaffirm the "hypothesis that atherosclerosis is fundamentally a metabolic disease subject to important dietary influences"[1] and do much to refute contentions that foods containing cholesterol should be avoided in general diets.

Arterial disease resembling that in human subjects was produced in Cebus monkeys fed diets high in cholesterol and low in sulfur amino acids. Within 2 to 8 weeks after initiation of the regimen serum concentration of cholesterol rose to levels of 300 to 800 mg. per 100 ml. "The hypercholesterolemia could be largely prevented by feeding 1 gram per day of dl-methionine or l-cystine as supplements to the diet." Also, the elevated cholesterol levels "could be restored to normal by feeding 1 gram of dl-methionine but only partially restored by 0.5 gram of l-cystine daily."

According to the investigators, the "vascular lesions were in the ascending aorta but extended from the valves of the left ventricle to the proximal portions of the carotid and femoral arteries . . . The aortic lesions were chiefly characterized by the presence of lipid-laden phagocytes and increase in collagen and elastic fibers. The lipids were in part cholesterol derivatives."

Cholesterol, an essential metabolite produced in intermediary metabolism,[2] is biosynthesized from dietary protein, fat, and carbohydrate.[3] Normally, its synthesis is exquisitely controlled to insure adequacy as well as to protect against an oversupply.[4] Furthermore, considerable evidence indicates that an increased cholesterol intake is not an etiologic factor in alleged aberrations of cholesterol metabolism such as atherosclerosis.

In widely variable amounts, cholesterol occurs in foods of animal origin—meat, poultry, fish and marine foods, eggs, milk products—all foods of great nutritive value.[3] Present knowledge in no way warrants alteration in the customary consumption of these foods because of their contained cholesterol.

Skeletal muscle of beef, lamb, pork, and veal provides but small amounts of cholesterol, approximately 0.06 Gm. per 100 Gm. moist weight of meat.[5] Since atherosclerosis may interfere sharply with normal nutrition, the patient should consume diets rich in protein foods (such as meat), vitamins, and fruit.[6] In addition to high quality protein, meat supplies valuable amounts of needed B vitamins and essential minerals.

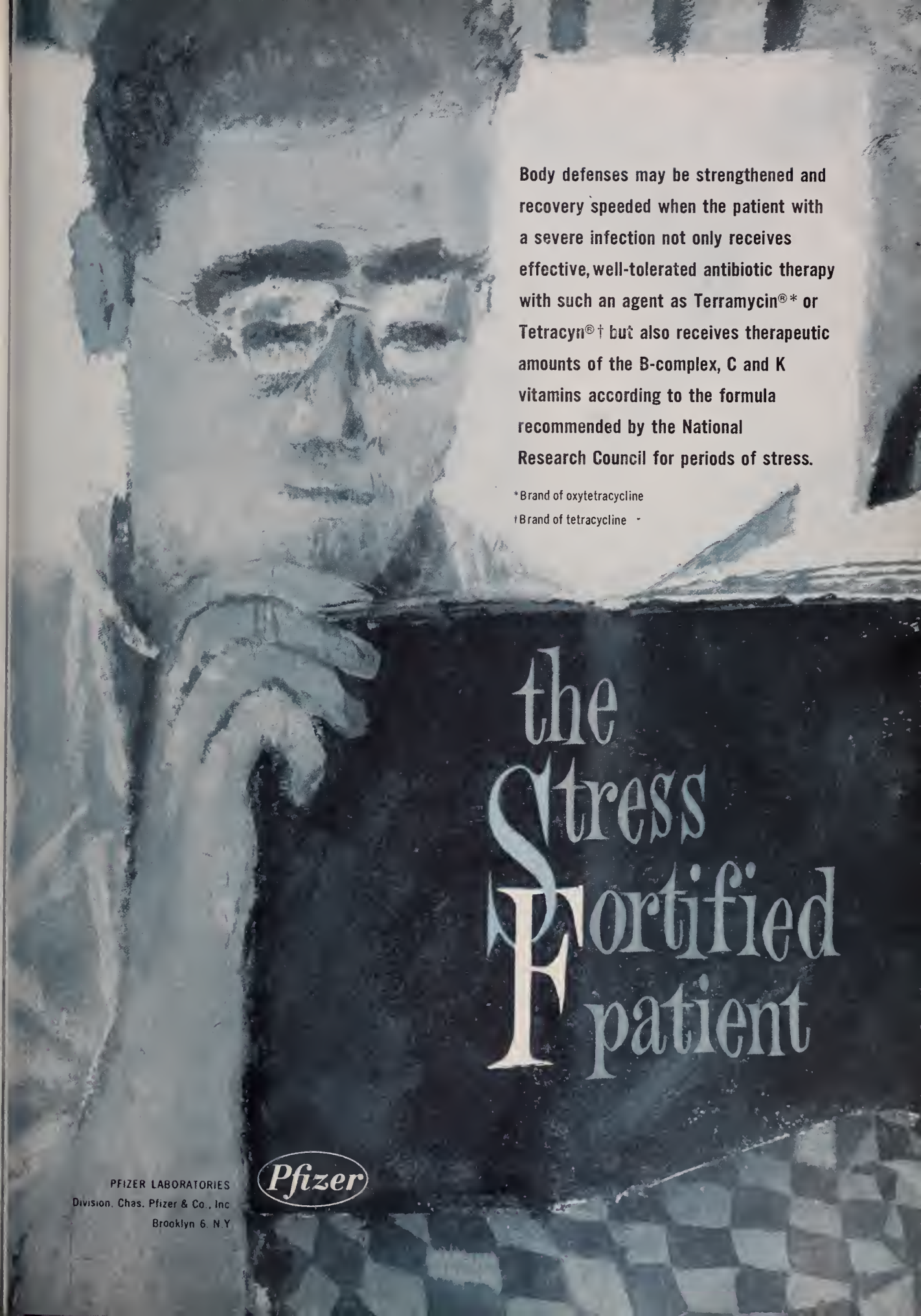
1. Mann, G. V.; Andrus, S. B.; McNally, A., and Stare, F. J.: Experimental Atherosclerosis in Cebus Monkeys, J. Exper. Med. *98*:195, 1953.
2. Okey, R.: Use of Food Cholesterol in the Animal Body; Relation of Other Dietary Constituents, J. Am. Dietet. A. *30*:231 (Mar.) 1954.
3. McLester, J. S., and Darby, W. J.: Nutrition and Diet in Health and Disease, ed. 6, Philadelphia, W. B. Saunders Company, 1952, pp. 517-518.
4. Editorial: The Biosynthesis of Cholesterol, J.A.M.A. *152*:1435 (Aug. 8) 1953.
5. Okey, R.: Cholesterol Content of Food, J. Am. Dietet. A. *21*:341 (June) 1945.
6. Wright, I. S.: Arteriosclerosis, in Stieglitz, E. J.: Geriatric Medicine, Medical Care of Later Maturity, ed. 3, Philadelphia, J. B. Lippincott Company, 1954, chap. 28, p. 413.

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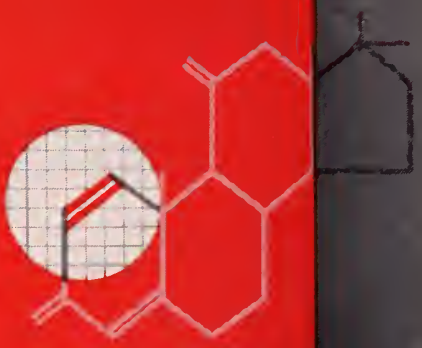
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Symposium on the Differential Diagnosis of Diseases Associated with Jaundice: I. Role of the History and Physical Examination

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ROCHESTER, MINN.

"No man is infallible in the diagnosis of jaundice." This statement made by Lord Moynihan some 60 years ago is still true today, in spite of the fact that we now have at our disposal a large number of diagnostic tools which were not available to physicians of his time. There is no question that these new tools, when properly used, have greatly improved our diagnostic accuracy. For this reason perhaps, there has been a growing tendency to overlook the fundamental importance of the clinical history and the physical examination and to rely almost too heavily upon laboratory procedures. Recent medical school graduates often seem to have the notion that the only necessary approach to the problem of jaundice is to order a battery of liver function tests and a needle biopsy of the liver. Such an approach, I am sure, does not always lead to the best diagnostic accuracy nor to the most advantageous treatment. Laboratory studies, valuable though they may be, must be interpreted in the light of all the information obtainable from a carefully taken history and a carefully performed physical examination. Unless the physician is in the habit of thoroughly evaluating this clinical information he will not be in a favorable position to make a diagnosis when the results of laboratory studies are equivocal, misleading or even in error.

I should like to review briefly some of the fundamentals in the diagnosis of jaundice which pertain to the history and physical examination. It will be impossible to consider in detail all of the many different diseases causing jaundice. Only general principles can be outlined and only some of the significant diagnostic points in regard to the common diseases can be discussed.

Classification of Jaundice

To begin with, it is helpful to keep in mind a classification of the causes of jaundice. That of McNee, though it no doubt is an oversimplification, is as useful as any I know. It divides all types of jaundice into three main groups: (1) hemolytic, (2) hepatocellular and (3) obstructive.

Hemolytic Jaundice. — Hemolytic jaundice is rarely confused with the other two types and for this reason I shall not devote more than passing attention to it. Jaundice of this type is due to excessive destruction of red blood cells and is not indicative of hepatic or biliary tract disease. It is associated with anemia and with an increased concentration of *indirect* reacting bilirubin in the blood. The most commonly encountered jaundice of this type is congenital hemolytic icterus, which is usually readily diagnosed by a positive family history, the presence of an enlarged spleen, the typical appearance of spherical microcytosis in the blood smear, and increased fragility of the red blood cells. An important diagnostic characteristic is the absence of a history of the passage of dark urine during attacks of jaundice. This distinguishes it from both obstructive and hepatocellular disease in which the jaundice is due to an increase in the blood level of *direct* reacting bilirubin which is regularly excreted in the urine.

From the Section of Medicine, Mayo Clinic and Mayo Foundation, Rochester, Minn. The Mayo Foundation is a part of the Graduate School of the University of Minnesota.
Read before the Florida Medical Association, Eightieth Annual Meeting, Hollywood, April 27, 1954.

One possible confusing factor with regard to the diagnosis of congenital hemolytic jaundice should be mentioned. Because of the excessive formation of bilirubin from the destruction of blood and its excretion into the biliary tract, gallstones are frequently found in this disease (approximately 60 per cent of cases). These can give rise to an obstructive type of jaundice, and the clinician may therefore find coexisting evidence of both types of jaundice (hemolytic and obstructive) in the same person. If the underlying hemolytic disease is recognized and if the frequent association of gallstones is appreciated, an accurate diagnosis of such mixed types of jaundice can frequently be made.

Before leaving the subject of hemolytic jaundice I should like to consider one other variety, which though definitely not hemolytic is best classified under this heading because the jaundice is due to an increase in the *indirect* reacting serum bilirubin. This is a condition called "constitutional hepatic dysfunction." This is characterized by mild, fluctuating or intermittent jaundice usually first appearing early in life and persisting for many years without progression. The only associated symptoms are fatigability and asthenia which seem to fluctuate with the jaundice. There is no history of abdominal pain, dark urine or pruritus, and the physical examination reveals no enlargement of the liver or spleen or other evidences of chronic hepatic disease or obstruction of the biliary passages. Except for the increased concentration of serum bilirubin, laboratory studies give entirely negative results, including studies for anemia, roentgen examination of the gallbladder and all liver function tests. This is an entirely benign condition, and the patient can be given complete reassurance with regard to it. Although constitutional hepatic dysfunction is not a common condition, its recognition is important since it may avoid much useless or dangerous therapy. Patients with this trouble have not infrequently been confined to bed for long periods because of the supposed presence of hepatitis. Others have been subjected to needless abdominal exploration.

Obstructive Versus Hepatocellular Disease. — From the practical standpoint, the most important problem in the diagnosis of jaundice is the differentiation of obstructive from hepatocellular disease. Obstructive disease is often amenable to surgical therapy, either curative or at least palliative. Patients with hepatocellular disease, on the other hand, are not benefited by surgical measures and tolerate them poorly, the risk of operation being high. The necessity of early accurate differentiation between the two types of jaundice is therefore obvious.

Hepatocellular jaundice is due to involvement of the cells of the liver by some diffuse disease process — inflammatory, degenerative or toxic in nature. Various etiologic agents may be responsible, such as viruses, chemicals, drugs, alcohol and dietary deficiencies. Acute hepatocellular jaundice is most commonly seen as infectious hepatitis, or homologous serum hepatitis, whereas the chronic form of the disease is represented by the various types of cirrhosis. Pain is seldom an important feature, though in rare instances it may be present and confusing in the diagnosis. The bile ducts are patent in hepatocellular jaundice, and usually evidence can be obtained to show that bile enters the duodenum. In some instances of acute severe parenchymatous disease of the liver, there is temporary complete suppression of the flow of bile, which seldom lasts longer than a few days. Evidence of disturbance of the metabolic functions of the liver may be found early in the course of hepatocellular disease, frequently even before the appearance of jaundice.

Obstructive jaundice is most often due to stones, strictures or neoplasms. Serious disturbances of the metabolic function of the liver usually are absent in the early stages. Pain is a much more common and prominent feature in the clinical course of patients with this type of jaundice than in those with hepatocellular disease, and oftentimes the diagnosis may hinge upon the evaluation and interpretation of the history of pain.

History

In any patient with icterus an accurate, detailed, chronologic account of symptoms both preceding and following the onset of jaundice is most important and helpful, and the physician should make every attempt to obtain complete information from the patient, his relatives and previous medical attendants.

Pain. — Attacks of pain, especially if they are associated with episodes of jaundice, chills or fever, are of particular significance. Almost all patients with jaundice from a stone in the common duct have had some severe pain at one time or another, and a good history of colic in a patient with jaundice is practically diagnostic of

this disease. Even when one is dealing with patients who have what seems to be painless jaundice, it is wise to inquire as to a past history of abdominal pain which could possibly have been biliary colic and which may have occurred weeks, months or even years previously.

The tendency of some patients to exaggerate symptoms and of others to minimize or forget them may make it difficult to assess the severity of pain and to determine whether true biliary colic has occurred. The difficulty of interpretation of pain is increased by the fact that biliary colic may be atypical in location and character in some 20 per cent of the cases of stone in the common duct. Further difficulty arises from the fact that other conditions may simulate the pain of a stone at this site. At the onset of jaundice due to a malignant lesion, pain is present in about 60 per cent of patients and is severe or colicky in less than half of these. In the other 40 per cent the disease runs a painless course. When pain from a malignant disease is present, it is apt to be constant and boring in character and is not usually confused with the severe episodic pain of biliary colic due to stone. The pain of chronic relapsing pancreatitis may simulate that of stone in the common duct exactly, but can often be distinguished from the fact that it tends to persist for many hours or even days at a time and may require repeated hypodermic injections of narcotics for relief, whereas the severe pain from stone in the common duct lasts only a matter of a few hours and is usually relieved by one hypodermic injection. Severe pain occurring during the course of hepatocellular jaundice such as that associated with hepatitis or cirrhosis presents a most difficult diagnostic problem, and fortunately is rare.

Postoperative Jaundice. — In patients who have had previous operations on the biliary tract, detailed information should be sought concerning the preoperative symptoms, the surgical findings and procedure, and the postoperative course. If stones were once present in the biliary system, they must be seriously considered as a cause of subsequent or persistent jaundice. Their presence will usually be marked by the occurrence of colic associated with chills, fever, sweats and increase of jaundice. A persistent discharge of bile from a postoperative fistula denotes the presence of some degree of obstruction of the common duct. Following cholecystectomy, such a biliary fistula is apt to be due to the presence of an overlooked stone in the duct or to inadvertent operative trauma with formation of a stricture of the common duct.

Symptoms of stricture almost always begin within the immediate postoperative period. Typically, patients in whom this disease develops were not jaundiced before cholecystectomy, but during a stormy postoperative course there develops a deep and persistent jaundice or else a biliary fistula which may close intermittently in association with pain, fever, chills, and deepening of the jaundice. Sometimes the symptoms of stricture will subside temporarily only to recur at intervals.

Painless Jaundice. — In taking a history from patients with painless jaundice, one should attempt to obtain information concerning the following points: (1) exposure to infectious hepatitis, (2) recent history of symptoms suggesting an infection of the respiratory or the gastrointestinal tract (premonitory symptoms of infectious hepatitis), (3) recent parenteral therapy, particularly injections of blood or plasma, (4) ingestion of medicines or exposure to other toxic substances that might cause injury of the liver (alcohol, carbon tetrachloride, methyl testosterone and so forth) and (5) previous removal of a malignant tumor.

Infectious hepatitis, though it occurs in epidemic form, is frequently sporadic and may attack persons in any age group. The diagnosis is relatively more difficult in middle-aged and elderly patients because of the more frequent occurrence of other types of jaundice during these years, and also because the onset and course of the disease in this age group are often atypical. A history of premonitory or accompanying symptoms such as an infection of the upper part of the respiratory tract, fever, malaise, anorexia, nausea, and vomiting is of distinct help in the diagnosis, but can be misleading because of the occasional occurrence of similar symptoms in the course of other diseases. Shaking chills are uncommon in infectious hepatitis, a fact which helps to distinguish it from stone in the common duct, stricture and other causes of obstructive jaundice.

Homologous serum hepatitis has become much more common within the last two decades because of the increasing use of blood, plasma, and blood products. Not uncommonly this disease occurs during the course of other illnesses and may cause considerable difficulty in diagnosis for this reason.

It is important to remember that jaundice does not appear until six weeks to six months after the injection of infected serum. Jaundice that has its onset before or after this range of time is not likely to be due to homologous serum hepatitis. It is equally important to remember that jaundice appearing during this period after the administration of blood or plasma must be considered as serum hepatitis until proved otherwise.

Mild jaundice is a fairly common symptom of portal cirrhosis, but usually there is other evidence which leads to the correct diagnosis, such as a history of excessive ingestion of alcohol, hematemesis or ascites. Usually the jaundice associated with portal cirrhosis is of mild or moderate intensity, and deep jaundice in this disease has a serious prognostic significance. Malignant tumors that metastasize to the liver may cause jaundice, but usually they do not unless the tumor in the liver is most extensive or unless it causes obstruction of the major bile ducts in the region of the hilus.

The symptom of pruritus does not distinguish between hepatocellular and obstructive jaundice though severe degrees of it are much more common in association with obstruction. Mild pruritus is fairly common with both types of jaundice, and severe itching may occur in cirrhosis of various kinds, particularly primary biliary cirrhosis.

Among patients with painless jaundice the passage of light or clay-colored stools has often been thought to indicate the presence of an obstructive type of jaundice. As a matter of fact, light-colored stools have no such significance, since they will be found almost universally among patients with hepatitis and other forms of hepatocellular jaundice as well as among those with obstruction. Duodenal intubation has demonstrated repeatedly that large quantities of bile may be entering the gastrointestinal tract at a time when the patient is having clay-colored stools.

Biliary Obstruction. — The demonstration of complete and persistent obstruction to the flow of bile is of considerable diagnostic importance because such a finding is characteristically due to carcinoma of the head of the pancreas, or common bile duct. Such complete obstruction is proved to exist when no bile is obtained by repeated duodenal intubation or by careful quantitative studies of the feces for urobilinogen. Hepatocellular disease rarely suppresses the flow of bile completely for more than a few days at a time, though it may do so temporarily in the early stages of the jaundice. Thus the demonstration of persistent failure of bile to enter the duodenum may be of great importance in diagnosing carcinomatous obstruction. Partial obstruction of the common bile duct (which is characteristic of common duct stone or stricture) cannot be diagnosed by these means, since some diminution of the flow of bile is also to be expected in hepatocellular disease. Intubation studies may give help in the diagnosis of jaundice if gross blood is aspirated from the duodenum, a finding which is not unusual in the presence of carcinoma of the ampulla or papilla of Vater. A history of melena in the course of jaundice has the same significance unless the patient has a pronounced bleeding tendency from severe hepatic disease or profound deficiency of prothrombin.

Physical Examination

The physical examination may give information of great diagnostic significance, or it may be of little or no help. The following are some signs worth looking for and noting: (1) depth of jaundice, (2) size and consistency of the liver, (3) splenomegaly, (4) palpable distended gallbladder, (5) tumors elsewhere in the body (especially in the region of the pancreas, supraclavicular lymph nodes and rectal shelf), (6) spider angiomata, (7) collateral venus circulation on the abdominal wall, (8) edema or ascites and (9) fetor hepaticus.

Although all degrees of jaundice may occur in both hepatocellular and obstructive disease, mild jaundice is rarely due to carcinomatous obstruction to the bile passages, which characteristically causes deep and progressive jaundice.

The degree of hepatic enlargement also does not differentiate between the two kinds of jaundice, since a liver extending down to the umbilicus and even below may represent enlargement due to obstruction of the bile ducts or to cirrhosis. An extremely large liver extending well into the lower quadrant of the abdomen is almost always the site of a malignant process. Metastatic carcinoma of the liver usually produces a coarsely nodular liver, and the hard, finely nodular liver of advanced portal cirrhosis has a characteristic feel. Splenomegaly when not associated with hemolytic jaundice is indicative of hepatocellular disease, though rarely it may be found in cases of long-standing

obstruction such as from stone or stricture of the common duct.

A palpable distended gallbladder in the absence of symptoms and signs of acute cholecystitis (that is, in the absence of hydrops of the gallbladder) is one of the most diagnostic of all physical signs and denotes the presence of a neoplastic obstruction of the common bile duct below the junction with the cystic duct. It can be demonstrated clinically in about 60 per cent of cases in which there is such obstruction. It is important to make a particular search for this sign, and sometimes it will be found only after repeated examination of the patient.

Spider angiomata may almost be called the trademark of cirrhosis and as such they are well worth looking for. They also may be found in acute hepatitis, sometimes appearing with great suddenness. Except for their occurrence in pregnant women and in a few otherwise normal persons, vascular spiders are indicative of parenchymatous disease of the liver or more rarely of long-standing obstruction. They can be found in the distribution of the superior vena cava, that is, on the face, neck, shoulders, upper extremities and upper part of the trunk. They may vary in size, but their pulsating central point and the spidery appearance of the surrounding net of small blood vessels serve to identify them. They should not be confused with cherry angiomata which almost all of us seem to acquire when we get past 40 years of age.

The finding of definite evidence of collateral venous circulation in the abdominal wall of a jaundiced patient is almost diagnostic of cirrhosis of the liver.

Brief comment may also be made concerning two other physical findings: the presence of edema and fetor hepaticus. In the patient acutely ill with recent jaundice the presence of edema points to serious injury to the parenchyma of the liver. Edema is not common in obstructive jaundice. Frequently, pitting edema of the sacrum, ankles and face precedes the development of hepatic coma in the presence of acute or subacute atrophy of the liver. Edema developing after a long period of jaundice is of less significance than that appearing early. Fetor hepaticus is a distinct sweet amine odor that is frequently noted on the breath of patients with hepatic disease. Its presence is apparently not always of serious prognostic significance, and it may be found in some patients with obstructive jaundice.

Summary

The fundamental role of a detailed history and a carefully performed physical examination in the differential diagnosis of diseases associated with jaundice is stressed. It is pointed out that familiarity with the natural history and possible variations of the commoner diseases that cause jaundice is of primary importance. Some special diagnostic points relating to the history and physical examination are discussed.

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Symposium on the Differential Diagnosis of Diseases Associated with Jaundice: II. Role of Liver Function Tests and General Laboratory Findings

JAMES L. BORLAND, M.D.
JACKSONVILLE

In this symposium, we come now to a consideration of the value of laboratory tests in the differential diagnosis of jaundice. It is the purpose of this discussion to outline in a general way the philosophy involved in the use of those tests called "liver function tests" rather than to attempt a complete discussion of all the laboratory examinations which may be brought to bear in the differentiation of jaundice. Of this group, only a few of the biochemical methods available to measure the liver function meet the requirements of suitability for the ordinary laboratory.

In any diagnostic situation the laboratory tests must be interpreted in the light of the clinical picture. The diagnosis depends upon the natural history of the disease as it develops in the patient; the laboratory tests merely serve as a check upon the reasoning of the physician. Thus in a given case, from the history and his observation of the patient, the physician must postulate the probable nature, duration and severity of the process, the reaction of the patient to his disease, and the presence or absence of other diseases or conditions. He then may predict that certain substances are increased or decreased in concentration or that there is an alteration in the function of certain cells. The results obtained from properly selected tests, which disclose these changes in concentration or cell activity, strengthen or weaken the physician's conclusions. Laboratory tests are meant to be guideposts to the clinical logician and, as such, are invaluable; but used alone or blindly as "liver function tests," they are likely to appear inconsistent and unreliable.

In order intelligently to select and interpret the results of any test of liver function the physician must bear in mind that disease patterns overlap, that the manifestations of the single pathologic process are a summation of various physiologic alterations, that conditions other than those of the liver affect the results, and that even though a single substance is being measured, the level in the tissues may be a summation of several factors. A test may give positive results in the same patient at different times for different reasons. A schematic outline is presented in figure 1, and a discussion of these individual points in detail follows:

A. The pathologic physiology of the disease may be complex. There are a few instances in which the jaundice is the result of a simple derangement of a single integer in the system of blood destruction and excretion. This is essentially true at the onset of many diseases producing jaundice, but in nearly all, with the passage of variable periods of time, multiple components of the system are affected, some stimulated, some inhibited; so the results of the process are an algebraic sum of these components. For example, it is evident from the onset of hepatitis that two factors must be considered: (1) a simple inhibition of the parenchymal cell due to toxic processes within the cell, and (2) a specific involvement of the mucous membrane of the upper part of the alimentary tract, particularly the duodenum.[1,2] It would seem reasonable to assume that this involvement also extends into the biliary tree.[3] The effect, in this case, is to have both "parenchymal liver cell disease" and "obstructive jaundice." The relative proportions of these two effects vary apparently from epidemic to epidemic, from strain to strain, from individual to individual, and at different times in the same person. It is also evident in diseases resulting in jaundice that there are many which disturb organs affecting the liver

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cell, notably the endocrine glands. Severe illness as such may affect the liver cell in this way. Even the affection of the parenchymal cell damage may become complicated in this disease. When the function of the liver cell, particularly in the periphery and periportal area, becomes stimulated rather than depressed, there is an overproduction of substances such as alkaline phosphatase, the production of which may be inhibited in other portions of the same organ. There is some evidence that the location of the cell in the lobule may have some relation to its function.

Fig. 1. — Factors in the Application of Tests

A. Pathologic physiology of the disease becomes complex
B. The basic mechanism of the test may be simple, but the result is complicated by
  1. Disease of tissues other than the liver affects substance or reaction measured
    a. Substance measured may come from tissues other than those directly involved in jaundice, as alkaline phosphatase (bone, pancreas), globulin, lipids
    b. Substance measured is complex, as mucoprotein, globulin plus lipids
    c. Level of substance in blood serum affected by multiple mechanisms
      (1) Elaboration in liver cell may vary in various locations in the liver
      (2) Regurgitation into blood
      (3) Elaboration by more distant organs
      (4) Stimulus to produce substance may be from disease other than that producing jaundice
      (5) Unknown substances produced by disease process may accelerate or inhibit reactions
  2. Various functions of the liver are affected independently of each other
C. Multiple factors affect the technical performance of tests

As a further example of the effects of multiple organ involvement, in jaundice resulting from a process which also obstructs the pancreatic duct, such as in carcinoma of the head of the pancreas, in addition to the effect upon the liver of the obstruction to the excretion of bile products, the tests reveal certain effects due to the occlusion of the pancreatic ducts as such. For instance, the metabolism of glucose is likely to be affected, both through the affection of the pancreas and of the liver. The alkaline phosphatase production is affected by both organs. Both secrete the substance through their external ducts with possible regurgitation if blocked. In addition, the production of the alkaline phosphatase in the liver is affected by the pericholangitis produced in the liver by the block in the pancreatic duct as well as by the effect of the block in the biliary tree.

A number of complex diagnostic situations reflecting these effects are illustrated in figure 2. It is evident from this outline that multiple processes will be involved in these cases with multiple effects. The effects will be an algebraic sum.

Fig. 2. — Complex Diagnostic Situations in Which Tests Are Valuable

A. Cases In Which the Diagnosis is Known
  1. In hemolytic icterus — between episodes of hemolytic activity and
    a. Onset of hepatitis
    b. Common duct stone
    c. Cholangitis or cholangiolitic process
  2. In cirrhosis — as in a,b,c
  3. Extrahepatic obstruction — with onset of liver damage
  4. In hepatitis — between simple prolonged convalescence and chronic hepatitis or chronic cholangiolitis
B. Cases In Which the Diagnosis is Unknown
  1. In sudden severe illness
    a. Between hepatitis and obstruction with cholangitis
    b. Between a and cirrhosis in an acute phase
  2. In slow onset of painless icterus
    a. Hepatitis versus cirrhosis (particularly in older persons) versus obstruction

B. The analysis of jaundice by laboratory measures becomes still further complicated when it is realized that diseases or conditions in the body other than those directly involved in the production of the icterus may affect the liver, the products of the liver, and products similar to those produced by the liver. For instance, fever is known to affect the liver function tests. Apparently in certain cases this effect occurs because the liver itself appears to be adversely affected by high temperature. Disease processes such as malignancy or inflammatory reactions, whether in the liver or in more distant organs, may affect both the carbohydrate and protein components of the mucoprotein compound. The phosphatase reactions may be affected by bone lesions, for example. A blood cholesterol level may be affected by such factors as familial tendencies, diet, and other considerations.

In selecting the test upon which to base a judgment in any given diagnostic situation, one must further take into consideration the degree of sensitivity of the test, the functions expected to be present, the basic mechanism of the test, and the technical factors affecting the test (a moist climate interferes with hippuric acid determination; the temperature at which material is collected affects some of the turbidity and floc-

culation reactions). The familiarity of the individual laboratory with the test is of importance. Since the test must be integrated with the physician's clinical appraisal, it is better to become familiar with a few tests than to take up each variation. That this course is of great importance is illustrated in figure 3. This figure indicates that an absolute norm in the thymol turbidity is possibly unattainable, and in my experience this observation applies to other tests as well. It is imperative that the laboratory performing the test be familiar with it, be experienced in performing it and have previously established the relative norm for itself, since this varies with the individual laboratory. Because of this technical variation, when given a choice of two possible methods, the physician should encourage the ordinary laboratory to use the grosser when the error is not enhanced. It is better, that is, to become familiar with the oral hippuric acid excretion test rather than the intravenous technic since the errors in the former tend to be dissipated in the mass.

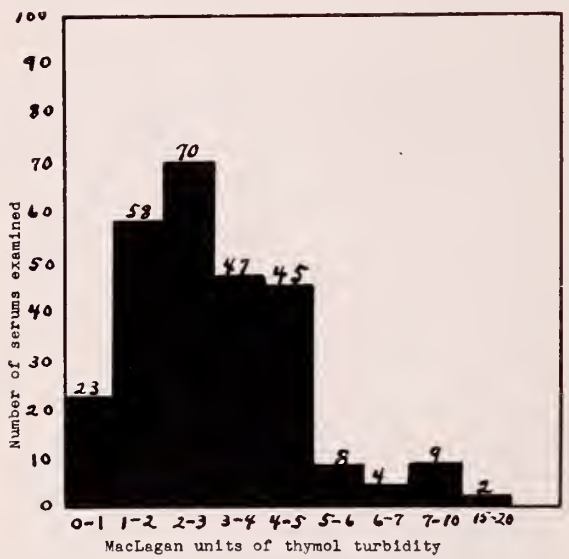


Fig. 3.— The results of thymol turbidity reactions on 266 presumably normal blood bank donors.

A convenient grouping of some of the tests commonly used to measure the complex variation of hepatic disease, as shown in figure 4, is:

A. Tests measuring the destruction of blood or the effects of products of blood destruction on various organs or the response of the body in general to these products are:

1. Examination of blood smears for regenerative activity
2. The various tests for lytic agents
3. Examination for bile in the urine, blood and stool
4. Examination for urobilinogen in the urine and stool

B. Tests measuring the reabsorption or regurgitation into the systemic circulation of the several fractions which are contained in bile include:

1. For urobilinogen in the urine and stool
2. For bile in the urine and stool
3. For Bromsulphalein excretion
4. For alkaline phosphatase
5. Van den Bergh test (1 minute)

C. Tests measuring the ability of the liver parenchymal cell to perform a given task at a give time include:

1. Observation of the results of carbohydrate metabolism, the glucose, galactose and fructose tolerance tests
2. Measurements of fat digestion, such as the formation of cholesterol esters, measurement of production of phospholipids, vitamin A tolerance
3. Tests of protein metabolism, such as the serum albumin concentration and the prothrombin time and its response to vitamin K
4. Measurement of the detoxifying function, such as the hippuric acid excretion test
5. Tests of the ability to excrete substances, such as bilirubin,[4] Bromsulphalein and urobilinogen in stool and urine

D. Tests which measure substances or combinations of substances appearing in response to pathologic processes or altered physiologic mechanisms not clearly or directly related to the destruction of blood, disturbances of the parenchymal cell or regurgitation of products include:

1. Alkaline phosphatase test
2. Total cholesterol test
3. Various tests revealing changes in the blood proteins and the relationship of these proteins to lipids (that is, the turbidity and flocculation tests)

It is to be noted particularly that many tests fall into more than one category, not because of an artificial division but because of an inherent complexity of the test, as the ensuing discussion will show. In the tests in groups A and B (fig. 4) there are several considerations that should be emphasized each time they are discussed:

1. The variability of the bilirubin in the blood is often used as a differential point between obstructive and other types of jaundice. The height and the manner or degree of increase or decrease, however, serve in only a limited way as a differential point in the diagnosis. It is common knowledge that a stone may act as a ball valve with fluctuation in the level and that edema in a duct which is obstructed by carcinoma may subside with equivalent drop in icterus. One of my cases illustrates the height to which the icterus in infectious hepatitis may rise. It is noteworthy in this case that at the time the icterus index was 410 units, the patient was walking around and feeling well. An exploratory laparotomy was performed because of the height of the jaundice. It was decided that the steady rise of serum bilirubin to this height implied an obstructive process. At operation, inspection and biopsy established the presence of hepatitis with evidence of extrahepatic obstruction.

2. The van den Bergh test, particularly the quantitative measure described by Watson,[5] gives extremely valuable information in that it tells whether or not the bilirubin in the blood has been passed through the liver cell. Unfortunately, it is of no value except in early jaundice. In late jaundice, no matter what the cause, a large proportion of the bilirubin has passed the liver and been reabsorbed. Further there is some doubt as to the nature of the differences between direct and indirect fractions.[6] The chief usefulness of this test probably is in differentiating mild hemolytic icterus from other types.[5]

3. The presence of bile and urobilinogen in the stool is extremely valuable when reliance may be placed on the tests. In my experience, however, these tests have not been satisfactory. I am unable to detect with certainty the color changes necessary to determine the presence of bile in the stool by the usual chemical tests and have decided that few technicians can do so. The same difficulty applies to the determination of urobilinogen in the stool.

4. Bile in the urine is of diagnostic value in early jaundice or in mild degrees of the disease. It is useful chiefly in detecting hemolytic processes. Its presence without measurable icterus in the blood serves as a distinguishing mark in diagnosing hepatitis in its early stages. The new tablet test has aided in the ease of performances.

5. The variability of lytic agents in the blood is well known and for the sake of brevity will not be discussed here.

Some of the tests in group B indirectly and incompletely measure the actual function of the liver cell. With this exception, the only tests actually devoted to the measurement of a single function of the liver cell at a given time are those in group C. These are the only ones, therefore, that could be properly called "liver function tests."

Fig. 4. — Tests Classified by Basic Function In Order of Sensitivity Within Group

A. Those measuring products of blood destruction or body response to these products

Antibodies	
Lysins	
Blood cell characteristics	
Bilirubin (blood, urine)	
Van den Bergh test	Urobilinogen* (stool, urine)

B. Those measuring reabsorption or regurgitation of excretions into bile

Van den Bergh	
Bromsulphalein	
Urobilinogen in urine	
Alkaline phosphatase	

C. Tests measuring ability of parenchymal cell to perform a given task

Excretory function	Bromsulphalein	Bilirubin excretion*†
Detoxification		Hippuric acid*†
Protein	Prothrombin time (vitamin K)†	
Fat	Cholesterol	
		Cholesterol esters*†
	Phospholipid	
Carbohydrate	Glucose	
	Fructose	Galactose*†

D. Tests measuring substances present in liver disease not clearly related to A, B and C

Cephalin cholesterol	Zinc sulfate flocculation*
Thymol turbidity	
Thymol flocculation	
Mucoprotein	

*Simple mechanism or single substance.
†Substance or mechanism controlled in liver and biliary tree.

The tests in group C by and large are reliable when performed in the average laboratory, provided they are performed frequently enough and due consideration is given the methods of collection of the material tested. As indicated in figure 4 the tests vary in "sensitivity." This difference is in part caused by variations in the range of normal value and in part caused by the variations

in the ease with which the parenchymal cell performs the individual task. For instance, it seems to handle sugars with greater ease than protein.

In selecting these tests, therefore, the physician must judge the severity of the process. To illustrate, the galactose tolerance test will give negative results in all cases of mild parenchymal disease, but would be of great value in differentiating severe hepatitis from infective cholangitis.

It may be helpful to discuss in more detail a few of the tests in order to illustrate the number of factors influencing the results of the tests and to point up the assertion that the result of the test is actually an algebraic sum, and the value of its components must be determined before the actual value of the test has any meaning.

Alkaline Phosphatase Level

1. Knowledge of the value of the serum level of alkaline phosphatase in the diagnosis of jaundice resulted from the observation that it was found to be elevated in cases of obstructive jaundice and normal in those of parenchymatous jaundice. The degree of its elevation still provides one of the few "absolutes" in disease of the liver, namely, any elevation above 30 K.A.U. signifies obstruction to the biliary tree. In this connection "biliary" types of cirrhosis produce extremely high levels, and a review of cases in the literature would indicate doubt that, if the level of alkaline phosphatase is below 30 K.A.U., these diagnoses should be made. Likewise, it is rapidly elevated in response to minimal degrees of obstruction and thus is of value.[7] Originally, the elevation of alkaline phosphatase in obstructive jaundice was regarded as regurgitation. Some doubt exists as to whether regurgitation occurs at all. Even if it does, it is evident that it is far from being a controlling factor in the serum level. Certain considerations are: [8-13]

a. That the alkaline phosphatase in the bile and pancreatic juice is not from the serum, but is actually produced by the liver and pancreas and the cells lining the ducts.

b. That the normally functioning liver cell does not remove alkaline phosphatase from the serum.

c. That there is frequent dissociation of the serum bilirubin and the phosphatase, particularly in biliary fistula and in infantile atresia of bile ducts.

d. Regenerating areas in the liver seem to produce more alkaline phosphatase.

2. Cases of jaundice resulting from parenchymatous disease alone were soon noted in which the alkaline phosphatase was elevated, though not in the degree of 30 K.A.U., and also cases of obstruction in the biliary tree with a normal alkaline phosphatase.

A consideration of the factors involved places the result as an algebraic sum and indicates that the exceptions are no less valuable than the rule and serve to illustrate most of the points discussed:

a. Multiple origins. The enzyme is present in most tissues and tends to be elevated in many diseases and conditions not involving the liver, even secondarily, such as bone lesions.

b. Variability in the site of production within the liver. Apparently in the absence of effects external to the liver, the serum level is maintained by the liver cells. It is evident that in the main the greatest area of production in the liver is in the region of the bile canaliculi, and anything which stimulates the cells in this area is likely to result in a greater level of enzyme in the serum than stimulation of cells elsewhere in the lobule. [9, 13, 14] Stimulation may be offset by destruction or impairment of the cell function. A sampling of the cases published in the literature suggests that the highest and most consistently positive findings of elevated alkaline phosphatase occur in those cases of cholangiolitic jaundice in which there is xanthomatosis, in the cholestatic cases or those cases of cholangiolitis in which the main ducts are chiefly involved. In these cases there may be both "regurgitation" and "stimulation."

c. Multiple influences on its production by the liver cells. These are other than from the stimulus of liver cell necrosis. Of itself, this does not result in elevation. Stimulus to the cells to produce the enzyme may occur in the same patient for two different reasons, supplementing each other if present at the same time, or maintaining the same serum level at different times in the same disease; or stimulus to some cells and depression of others may "cancel out" and result in a normal serum level. It is known that, when the pancreatic duct is obstructed, a pericholangitis develops with a resultant rise in alkaline phosphatase even in the absence of jaundice.[15] This has been observed in the dog with a subsequent decline and a secondary rise at the time a fatty infiltration of the liver occurred,[16] and it has been sugggested that this fatty infiltration may "simulate a moderate biliary obstruction."[17]

In the case in figure 5, the early rise and subsequent fall of alkaline phosphatase, therefore, is comparable to that occurring in the experimental animal whose pancreatic duct has been occluded.

Fig. 5.—Case Illustrating Multiple Influence on Tests

Mr. K. K.
Diagnosis: Carcinoma of head of pancreas

Weeks:	1	2	4	6
Cephalin flocculation (24 hrs.)	1+	1+	0	0
Cephalin flocculation (48 hrs.)	1+	1+	0	0
Thymol turbidity			5.5	5.5
Thymol flocculation			0	0
Alkalin phophatase	35.0	24.8	12.2	0
Icterus index		144	159	149
Total bilirubin	7.8	11.8		

The serum level of alkaline phosphatase, therefore, is the algebraic sum of many influences which require both clinical observation and other tests to evaluate at moderate levels. Taken alone as a measure of "parenchymatous disease" or "obstruction," it has little meaning.

If these points are borne in mind, however, it is valuable in that it is capable of indicating stimulation as well as depression of the liver cells, it is capable of distinguishing areas of stimulation in the liver, it provides "absolutes" when extremely high, and it is technically reliable.[18]

Turbidity and Flocculation Reactions

The changes in the chemistry of the proteins are the most constant concomitant of any type of hepatic disease. This, however, is complicated in the application of the tests to the function of the liver by an incomplete knowledge as to the exact source and chemistry of the various types of proteins and in inadequate practical methods for the measurement of each. The liver is apparently involved in the origin and regulation of both albumin and globulin fractions. Whether it is the sole source or the sole control of the albumin is unknown. There is certainly evidence that some of the globulins at least are compounded elsewhere.[19] It is evident that the serum levels of these substances are subject to multiple controls. It is beyond doubt that variations in both albumin and globulin fractions occur as a result of disease processes not ordinarily regarded as directly related to disease in the biliary tree or excessive blood destruction. In the main, in damage to the liver cell there is an inability to maintain serum albumin and a stimulus to produce globulin. At least in the latter phase, however, the type of globulin produced appears to vary with the type of disease process,[20] the strain of the infecting organism, the immune processes, the duration, the transport of fat, and other variables. In the tests based on these proteins, the level of substances measured will be an algebraic sum of the stimulus of the cells to produce these proteins and depression of their ability to do so.

The exact chemistry of the precipitant formed in the turbidity and flocculation reactions has been determined only to a limited degree. The protein involved in most of these is some type of globulin. Increases in alpha globulin are not reflected directly in any of the complexes except that of the mucoprotein. In the main, the tests are a measure of the gamma globulin in its relationship to other proteins and lipids, but various complexes involving beta globulin also precipitate. The precipitate and precipitant in the majority of the cases is known. What is not known is the number of the other types of precipitates that may be formed by variable types of globulin, particularly as related to fats and what precipitant may affect these. In the various tests of this type in common use today, the precipitate results from an interrelationship between gamma globulin and albumin; one may take the basic mechanism of the test and add to it gamma globulin and a precipitate is formed at a constant concentration. Likewise, normal human serum albumin may be added to this and be found to prevent quantitatively the development of the reaction. Thus, the precipitant is not solely dependent on the absolute quantitative level of the globulin, but also on its concentration relative to the albumin which is keeping it in the solution. In addition, there are probably other compounds which tend to have this effect. This simple relationship seems to be true in all tests of this type in common use today, and it is said that the zinc sulfate solution remains this simple and can act as a measure of gamma globulin alone. Certainly the thymol and cephalin precipitates may be affected by accumulation of immune globulin and are known to be precipitated by certain concentrations of beta globulin, either as part of an infectious or cirrhotic response, or in its capacity in the transport of fat.

In disease, it is known that there are qualitative changes as well as quantitative changes in the albumin and globulin fractions. For instance, in hepatitis the gamma globulin is either modified or there is some other substance present, which tends to induce precipitation at a lower concen-

tration in relation to normal serum albumin than would otherwise occur.[21-26] Likewise, the serum albumin obtained from patients with obstruction of the biliary tree contains some substance which tends to inhibit the precipitation of the flocculation portion of the reaction at a concentration other than that at which it would normally occur (fig. 6). It is evident, for instance, in the thymol reaction that the factors mentioned do not affect the development of the turbidity precipitation in the same degree as the flocculation, and that in this reaction there are two possible precipitates, subject to different control.



Fig. 6. — Showing the inhibition exerted by the serum of a patient with an obstructive jaundice toward the development of a positive thymol flocculation reaction in the serum of a patient with infectious hepatitis. The photograph was taken 60 hours after a standard thymol turbidity and the 18 hour flocculation tests were run on samples of serums mixed as follows: 1. Serum of hepatitis patient (A) with strong thymol reactions plus an equal amount of serum from a normal male (B). 2. Serum of patient (A) plus an equal amount of serum of a patient with obstructive jaundice (C) (Mr. K. K.). 3. Serum of patient (A). 4. Serum of patient (C). 5. Serum of patient (C) plus an equal amount of serum of a normal male (B).

In these reactions, therefore, there are multiple chemical forces tending to form a precipitate, and multiple forces tending to keep the precipitate in solution. Whether the reaction to the test is positive or negative is the result of an algebraic sum of these forces. This fact is commonly appreciated when the test gives positive results, but what is not so widely understood is that negativity may be dynamic rather than passive, and that all factors may vary in the same person from time to time, although the actual algebraic sum may be the same. In evaluating these particular reactions, therefore, one must know roughly the type of disease, its duration, its severity, whether or not it is accompanied by fever, whether the person is ill or convalescing. In addition, there is some reason to believe that in the virus-producing infectious hepatitis there is some variation in reaction from strain to strain, and it is probably necessary also that some estimate be made of the type of strain in these cases. Despite the complexity, however, a proper estimate of the probable factors involved may be made and the use of these multiple reactions becomes one of the most valuable and significant guides in medicine. To illustrate, take the case of Mr. K. K. (fig. 5), in whom jaundice developed from the effects of carcinoma of the head of the pancreas. The flocculation reactions were negative; the thymol turbidity was normal. In this case then, the serum of this patient was placed against that of a patient having an infectious hepatitis with a strong flocculation reaction (fig. 6) and the flocculation reactions resulting from the thymol reagins actually were inhibited. The reactions were not negative because of simple lack of stimulation, but inhibitory substances were present in the serum of the patient in sufficient degree to prevent the development of these reactions.

The various turbidity and flocculation tests, therefore, are not tests of the function of the liver cell but measures of the mesenchymal reaction to certain disease processes.[27] That these disease processes involve damage to the liver cells appears to be secondary. The chief value of these tests lies in indicating types of disease processes present and indicating tissue reactions that may affect other tests. Thus they are invaluable to the logician in his clinical analysis of the patient. They are particularly sensitive indicators of these reactions. Also, they are simple to run, although exact norms are difficult to establish and variations in temperature and hydrogen ion concentration are likely to produce serious errors.

Mucoprotein[27-32]

The serum mucoprotein is a glycoprotein complex. It may be separated from the albumin and other globulins. Electrophoretic evidence indicates that the isolated mucoprotein resembles the alpha (1) globulin in serum. Its complete structure is not yet fully determined. The estimation of either the protein or glycogen component may serve as a measure for the whole.

The changes in the mucoproteins appear to be independent of the abnormality revealed by serum bilirubin, thymol turbidity, zinc sulfate, alkaline phosphatase, prothrombin time, and Bromsulphalein. There is evidence that the mucoproteins are multiple and that the multiplicity results from varying sources, functions and chemical potentials. It is known that some of them

are pathologico-physiologic, being produced from the connective tissue matrix at the margins of inflammatory lesions, new growths, and other injuries. In the normal person the level of the conglomerate mucoprotein is a constant within definite limits. The liver appears to be sufficiently concerned in this homeostasis that affections of that organ produce detectable variations in the serum level. In general the effect on the serum level is the result of stimulation or depression of the production of this particular component by the liver cell.

The mucoprotein appears to be rather consistently but not inevitably lowered in parenchymatous disease. It seems to correlate roughly with the severity, and is thus lower in cirrhosis than in hepatitis, although experience has not been sufficient to determine whether the degree of either the elevation or the suppression is of significance. Alpha globulin electrophoretically does not appear to be lowered in these two conditions. Technical difficulties, however, mask the true alpha globulin as determined by electrophoresis. That the alpha globulins are lowered is indicated not only by the drop in the mucoprotein but also by the reported absence of polysaccharide c-reactive protein in these conditions, the latter being a known component of the alpha globulin complex. It has been observed that occasionally the alpha globulin tends to become elevated in hepatitis which is becoming chronic. The alpha (2) globulin has been noted to be increased in a case of Weil's disease and in other febrile infections.[19] There is some evidence that the relationship of the polysaccharide content to the protein content in the mucoprotein complex is of significance.

The mucoprotein level in the serum as well as its composition, therefore, seems to be the result of both intrahepatic and extrahepatic processes. The ordinary tests performed grossly do not subdivide the mucoprotein complex or indicate its sources.

The mucoprotein test is another in which extrahepatic complications may override the changes resulting from depression of the liver cell function and result in a normal or elevated mucoprotein in these situations in which a lowered one might be found.

As a tool for diagnosis, therefore, these tests have certain values:

1. Mucoprotein is produced by the liver cell in normal states in sufficient quantity with sufficient degree of homeostasis to maintain a more or less constant level in the blood.

2. This level rises with stimulation of hepatic parenchymal cells and falls when the function is depressed.

3. For the ordinary laboratory it is the only practical test which can serve as even a crude measure of the alpha globulin.

Bromsulphalein Excretion Test

The Bromsulphalein excretion test is one of the tests which reflects minor degrees of impairment of the liver cell. The polygonal cell of the liver is chiefly responsible for the removal of Bromsulphalein from the blood stream.[33, 34] This test has been chosen for discussion because it illustrates the multiplicity of factors to be weighed in its interpretation.

I. Bromsulphalein is not handled solely by the liver. There is evidence that tissues outside of the liver may remove it. It has been shown that in the hepatized, eviscerated and nephrectomized dogs, 50 per cent of the dye disappears in one hour from the circulating blood.[35] This factor probably plays only a minor role unless the liver is damaged. Thus the clinician in evaluating the results of the test must estimate the degree of damage to the liver in order to decide whether the rate of removal being measured is a function largely of the liver or of other tissues.

II. The mechanisms within the liver responsible for the handling of Bromsulphalein are susceptible to multiple influences.

A. In the liver the dye is removed from the serum by the polygonal cells, and the rate of removal is the function of:

1. The hepatic blood flow. Anything which impairs the blood flow, such as circulatory failure, may result in a slow removal of the Bromsulphalein.

2. The concentration between plasma and cell.

3. "Saturation" of the cell. Presumably saturation of the cell may be reached by:[33, 34]

a. Interference with the excretory function or regurgitation into the sinusoids due to obstruction.

b. Decrease in the rate of excretion by the polygonal cell. Not too much is known of the latter. Apparently Bromsulphalein is removed less readily than bilirubin and other substances, and therefore a dissociation of the dye from the bilirubin is possible in disease of

the liver cell. A previous injection within a few hours results in a slower uptake of a second dose, although after a day's interval the uptake is not retarded.

c. Blocking of sinusoids by material other than Bromsulphalein, bilirubin, dyes, and the like. In the interpretation of the test, these factors must be individually weighed. The size of the dose, therefore, affects the saturation point as well as repetition. Metabolic substances such as proteins, carbohydrates and fats apparently do not affect the test. Accordingly, the simultaneous use of hippuric acid or various sugar tests would not affect the Bromsulphalein. It may, therefore, be clearly dissociated from these tests as well as those measuring protein derangement.

III. Bromsulphalein is interfered with by general body conditions. Fever as such will increase the retention.

The value of the test lies in the fact that in slight jaundice it directly measures a function of the liver cell at a given time, that it is highly sensitive to minor changes, that its technical performance is nearly foolproof, and that it may conveniently be performed in conjunction with any other test except the bilirubin excretion test. Thus it may serve as a check upon other tests.[3,6] For instance, it may clarify the meaning of an elevated alkaline phosphatase in slight jaundice. It is more or less useless in moderate to severe degrees of jaundice.

Summary

The clinician has at his command tests capable of giving him much information concerning a jaundiced patient; they may be used in differentiating the cause of the illness in so far as they detect and measure stimulus or depression of liver cells and the manifold reactions of various tissues to the presence of different types of processes. They are unnecessary in most situations, the diagnosis being apparent from the history of the course of the disease and the physical examination of the patient, but as the effects of the disease and its manifestation become a more complex algebric sum, the tests are needed. As has been pointed out, the factors in this sum usually become so numerous that no single test or group of tests will fill in sufficient integers for its solution. An example of the changing pattern of the tests with increasing complexity of the disease is shown in figure 7.

Fig. 7.—Changing Pattern of the Tests with Increasing Complexity of the Disease

Disease Becomes Complex	Test Group (Fig. 4)
Hemolytic icterus	
1. Uncomplicated	A ± characteristic change B, C, D negative
2. Uncomplicated (fever)	A, B, C, D positive (except some of C, for example, hippuric acid)*
3. Liver cell damage	A ± characteristic change B negative (except those included in A) C ± (according to degree of sensitivity) D positive
4. Excretory block†	A ± characteristic change B positive C positive (according to degree) D negative (mainly inhibited excretory block overriding)

*The effect of fever on some is unknown, for example, hippuric acid excretion.

†Common duct stone.

Multiple tests must be run, usually at least one from each group: the "liver profile" so-called. The selection is determined by the physician's estimate of the number of the integers present in the sum of the individual case. Since, however, the ability of the liver cell is not "all or none" so that some functions are performed more readily than others, and since some tests may be affected by both external and internal conditions other than the disease process being investigated, a number of "profiles" need to be included in the clinician's repertoire.

References

1. Lucke, B.: Pathology of Fatal Epidemic Hepatitis, Am. J. Path. 20:471-593 (May) 1944.
2. Wilcox, W.: Brit. M. J. 297, 1916, in Rolleston, H. D., and McNee, J. W.: Diseases of the Liver, Gall-Bladder and Bile-Ducts, ed. 3, The MacMillan Company, 1929.
3. Watson, C. J., and Hoffhauer, F. W.: Problem of Prolonged Hepatitis with Particular Reference to Cholangiolitic Type and to Development of Cholangiolitic Cirrhosis of Liver, Am. Int. Med. 25:195-227 (Aug.) 1946.
4. Soffer, L. J., and Paulson, M.: Residual Hepatic Damage in Catarrhal Jaundice as Determined by Bilirubin Excretion Test, Arch. Int. Med. 53:809-813 (June) 1934.
5. Watson, C. J.: Some Newer Concepts of Natural Derivatives of Hemoglobin; General Considerations; Serum Bilirubin and Bilirubinuria; Erythrocyte Protoporphyrin, Blood 1:99-120 (March) 1946.
6. Klatskin, G., and Drill, V. A.: Significance of "One-Minute" (Prompt Direct Reacting) Bilirubin in Serum, J. Clin. Investigation 29:600-676 (June) 1950.
7. Shay, H., and Siplet, H.: Minimal Yet Adequate Program of Liver Function Studies in Differential Diagnosis of Jaundice, Am. J. Med. 4:215-227 (Feb.) 1948.

8. Wang, C. C., and Grossman, M. I.: Nonexcretion of Serum Alkaline Phosphatase by Liver and Pancreas of Normal Dogs, Am. J. Physiol. 156:256-260 (Feb.) 1949.
9. Cameron, G. R., and Oakley, C. L.: Ligation of Common Bile Duct, J. Path. & Bact. 35:769-798 (Sept.) 1932.
10. Grossman, M. I.; Wang, C. C., and Wang, K. J.: Alkaline Phosphatase Correlation of Histochemical Demonstrability in Pancreatic Tissue with Presence in Pancreatic Juice, Proc. Soc. Exper. Biol. & Med. 78:310-311 (Oct.) 1951.
11. Cantarow, A.; Wirts, C. W.; Snape, W. J., and Miller, L. L.: Effect of Certain Choleretic Agents on Excretion of Pigment and Bromsulfalein in Bile, Am. J. Physiol. 154:506-512 (Sept.) 1948.
12. Drill, V. A.; Annegers, J. H.; Snapp, F. E., and Ivy, A. C.: Effect of Biliary Fistula on Bromsulphalein Retention, Serum Phosphatase and Bile Phosphatase, J. Clin. Investigation 24:97-105 (Jan.) 1945..
13. Gutman, A. B.; Olson, K. B.; Gutman, E. B., and Flood, C. A.: Effect of Disease of Liver and Biliary Tract Upon Phosphatase Activity of Serum, J. Clin. Investigation 19:129-152 (Jan.) 1940.
14. Gomori, G.: Distribution of Phosphatase in Normal Organs and Tissues, J. Cell & Comp. Physiol. 17:71-83 (Feb. 20) 1941, cited by Burke, J. O.: Serum Alkaline Phosphatase in Liver Disease: Concept of Its Significance, Gastroenterology 16:660-668 (Dec.) 1950.
15. Shay, H.; Komarov, S. A.; Siplet, H., and Lorber, S.: Effect of Pancreatic Duct Ligation and Induced Acute Pancreatitis on Serum Alkaline Phosphatase in Dogs, Gastroenterology 23:460-461 (March) 1953.
16. Freeman, S., and Ivy, A. C.: Influence of Pancreas on Serum Phosphatase in Dogs, Am. J. Physiol. 118:541-548 (March) 1937.
17. Canepa, J. F.; Tanturi, C. A., and Banfi, R. F.: Experimental Study on Lipocaic, Surg., Gynec. & Obst. 86:341-356 (March) 1948.
18. Tyor, M. P., and Cayer, D.: Differential Diagnosis of Jaundice. Relative Value of Clinical Impression, Laboratory Tests, and Aspiration Liver Biopsy, Gastroenterology 24:63-70 (May) 1953.
19. Sterling, K.: Hepatic Function in Weil's Disease, Gastroenterology 15:52-58 (May) 1950.
20. Spellberg, M. A.; Cohn, C.; Wolfson, W. A., and Shore, C.: Symposium on Liver Disease; Serum Globulin Fractions as Index of Hepatic Dysfunction, Gastroenterology 14:11-19 (Jan.) 1950.
21. Maclagan, N. F.: Laboratory Tests in Diagnosis of Liver Disease; Report on 3 Procedures, Brit. M. J. 2:363-365 (Sept. 16) 1944.
22. Maclagan, N. F.: Liver Function Tests in Diagnosis of Jaundice; Review of 200 Cases, Brit. M. J. 2:197-201 (Aug. 9) 1947.
23. Rennie, J. B., and Rae, S. L.: Differential Diagnosis of Jaundice by Flocculation Tests, Brit. M. J. 2:1030-1032 (Dec. 27) 1947.
24. Popper, H.; Steigmann, F.; Dyniewicz, H., and Dubin, A.; Use of Thymol Turbidity as Lipid Absorption Test: Experiences with Thymol Turbidity and Zinc Sulfate Turbidity Tests Under Physiologic and Pathologic Conditions, J. Lab. & Clin. Med. 34:105-115 (Jan.) 1949.
25. Gray, S. J., and Barron, E. S. G.: Electrophoretic Analyses of Serum Proteins in Diseases of Liver, J. Clin. Investigation 22:191-200 (March) 1943.
26. Steigmann, F.; Popper, H.; Hernandez de la Portilla, R., and Shulman, B.: Flocculation Tests in Diagnosis of Hepatobiliary Disease, Gastroenterology 13:9-19 (July) 1949.
27. Popper, H., and others: Electrophoretic Serum Protein Fractions in Hepatobiliary Disease, Gastroenterology 17:138-162 (Feb.) 1951.
28. Greenspan, E. M.; Tepper, B.; Terry, L. L., and Schoenbach, E. B.: Serum Mucoproteins as Aid in Differentiation of Neoplastic from Primary Parenchymatous Liver Disease, J. Lab. & Clin. Med. 39:44-56 (Jan.) 1952.
29. Havens, W. P. Jr.; Eichman, H. L., and Knowlton, M.: Failure to Find C-Reactive Protein in Viral Hepatitis, Proc. Soc. Exper. Biol. & Med. 75:108-110 (Oct.) 1950.
30. Winzler, R. J.; Devor, A. W.; Mehl, J. W., and Smyth, I. M.: Studies on Mucoproteins of Human Plasma, J. Clin. Investigation 27:609-616 (Sept.) 1948.
31. Winzler, R. J., and Smyth, I. M.: Studies on Mucoproteins of Human Plasma; Plasma Mucoprotein Levels in Cancer Patients. J. Clin. Investigation 27:617-619 (Sept.) 1948.
32. Longsworth, L. G.; Shedlovsky, T., and MacInnes, D. A.: Electrophoretic Patterns of Normal and Pathological Human Blood Serum and Plasma, J. Exper. Med. 70:399-413 (Oct.) 1939.
33. Mendeloff, A. I.; Kramer, P.; Ingelfinger, F. J., and Bradley, S. E.: Studies with Bromsulphalein; II. Factors Altering Its Disappearance from Blood After Single Intravenous Injection, Gastroenterology 13:222-234 (Sept.) 1949.
34. Cohen, E. S.; Althausen, T. L.; Uyeyama, K., and Treager, H.: Studies on Bromsulfalein Excretion: 1. Results of Successive Daily Bromsulfalein Tests and Effect of Galactose on Bromsulfalein Excretion, Gastroenterology 17:572-577 (April) 1951.
35. Cohn, C.; Levine, R., and Streicher, D.: Rate of Removal of Intravenously Injected Bromsulphalein by Liver and Extrahepatic Tissues of Dog, Am. J. Physiol. 150:299-303 (Aug.) 1947.
36. Marion, D. F.: Delayed Convalescence Following Acute Hepatitis; Clinical and Laboratory Evaluation, Gastroenterology 8:717-723 (June) 1947.

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President McEwan's Address

Eighty-First Annual Meeting

Scheduled for Publication

June Issue

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Symposium on the Differential Diagnosis of Diseases Associated with Jaundice: III. Role of Liver Biopsy

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MIAMI

The use of needle biopsy of the liver as a diagnostic procedure has received much favorable attention for the past 15 years, and both its value and its limitations in the differential diagnosis of jaundice can be conveniently presented in four broad categories: The first concerns its ability to distinguish between obstructive jaundice uncomplicated by infection, viral hepatitis and portal cirrhosis. In differentiating these three conditions the liver biopsy probably plays its greatest diagnostic role. The second concerns a group of conditions which are characterized histologically by obstructive jaundice in conjunction with either acute or chronic pathologic changes of the intrahepatic biliary system. The third concerns its place in the diagnosis of tumors and certain specific infections, and the fourth concerns its use as an adjunct in the diagnosis of hemolytic jaundice.

Obstructive Jaundice

In cases of obstructive jaundice uncomplicated by infection the principal pathologic change is a concentration of bile thrombi around the centrolobular veins without evidence of inflammation or scarring. Neither the exact cause nor the location of the obstruction is demonstrable, but when bile stasis of this type occurs and significant changes are not visualized in the remaining areas of the hepatic lobule, the obstruction will usually be found to involve the extrahepatic biliary system.

Among the more prominent histologic features of acute nonfatal hepatitis are heavy infiltrations of inflammatory cells both in the portal canals and also in the remaining areas of the liver lobule. Upon close examination the inflammatory cells may be identified as mononuclear cells often accompanied by a few eosinophilic leukocytes. Polymorphonuclear leukocytes are sparse and are not seen in sufficient number to be significant.

Peculiar forms of degenerated liver cells resembling the Councilman body of yellow fever are frequently seen in cases of viral hepatitis and are seldom observed in other forms of liver disease. While not pathognomonic of hepatitis, they are often helpful in establishing the diagnosis.

Although clinical jaundice is often present in the acute phase of hepatitis, evidence of bile retention in the biopsied material is usually limited to a few small bile thrombi distributed at random throughout the lobule.

In cases of portal cirrhosis the biopsied material presents the familiar histologic changes which occur in this condition. The cirrhotic liver is a micronodular organ, and each of the nodules is surrounded by scarred portal canals containing numerous bile ducts. The central hepatic veins are usually incorporated in the scarred areas and often cannot be differentiated histologically from the portal veins. For this reason the islands of liver parenchyma which remain are referred to as pseudolobules.

Obstructive Jaundice with Pathologic Changes of Intrahepatic Biliary System

When inflammation of the portal canals and jaundice occur together, it is often difficult to determine whether the pathologic changes represent a primary infection of the intrahepatic biliary system or whether they are secondary manifestations of a tumor, a calculus or a liver abscess, and in most instances the evidence is not clear enough to warrant a definite statement on histologic grounds alone. Biopsied material will usually serve, however, to eliminate viral hepatitis and portal cirrhosis as possible etiologic factors.

If the obstruction is not relieved, the portal canals become scarred, bile stasis continues, and the histologic appearance of obstructive biliary cirrhosis finally supervenes.

Read before the Florida Medical Association, Eightieth Annual Meeting, Hollywood, April 27, 1954.

Hepatic diseases in which the combination of jaundice and portal inflammation or scarring comprises the principal pathologic feature are referred to under several names since there is no uniform terminology. If inflammatory exudate is actually found within the lumina of the bile ducts, the disease is designated as suppurative cholangitis; if the inflammatory cells are limited to the supporting tissues of the portal canals, the term pericholangitis is employed; and when scarring of the canals is advanced, the diagnosis of obstructive biliary cirrhosis is used. "Cholangiolitis," "cholangiolitic hepatitis" and "cholangiolitic cirrhosis" are acceptable clinical terms, but so far no consistently uniform histologic counterparts have been found for the clinical entities that bear these names. In some of the cases so designated biopsied material reveals evidence of either acute or chronic pericholangitis with bile stasis.

Tumors and Specific Infections

Tumors and certain specific infections, such as tuberculosis, can be identified provided that material from an affected area is obtained in the course of the procedure. Since however, these conditions affect the liver in a focal rather than in a systemic manner, one obviously cannot guarantee that suitable material will be obtained.

Hemolytic Jaundice

In acute acquired hemolytic anemia with clinical jaundice the liver cells contain abundant deposits of hemosiderin which can be differentiated from other pigments by a specific stain known as the Prussian-blue reaction. While helpful in confirming the diagnosis, a liver biopsy is seldom required in this condition.

Comment

Most needle biopsies of the liver are without complication, and both the morbidity and the mortality are minimal if a few precautions are taken. While statistics vary, a recent review of more than 20,000 cases indicates that the true mortality is less than 1:1,000.[1] The most frequent serious complication results from excessive bleeding, and consequently the procedure is usually contraindicated in patients who manifest a bleeding tendency or impaired blood coagulation.

Because of the possible leakage of bile the risk is increased in the presence of severe jaundice, and a few cases of bile peritonitis following biopsy have been reported. This complication, however, rarely occurs, and for this reason the presence of jaundice is not regarded as a contraindication to biopsy. When a liver biopsy is to be employed, it is recommended that it be performed as soon as possible and not saved as a last resort after exhaustive clinical and laboratory studies. Early biopsy is especially important for diagnosis in the jaundiced patient since prolonged obstruction, if unrelieved, inevitably results in either inflammatory or sclerotic changes of the intrahepatic biliary system.

Though not without some danger, needle biopsy of the liver is regarded as a relatively safe procedure, and those who use it consistently believe that the gain is well worth the risk.

References

1. Zamcheck, N., and Klausenstock, O.: Liver Biopsy. II. The Risk of Needle Biopsy, New England J. Med. 249:1062-1069 (Dec. 24) 1953.

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Proceedings of Eighty-First Annual Meeting
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Post Partal Heart Disease

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This article is written primarily so that doctors, being the more familiar with and cognizant of this type of syndrome, may recognize the condition, its predisposing and precipitating factors, may offer the patient the therapeutic possibilities of the newer drugs and may assist in investigating a more specific etiology.

Etiology and Classification

The condition known as post partal heart disease is, in the opinion of many, not an idiopathic form of myocarditis and in their opinion, therefore, should not be categorically listed as such. To date, the reference literature is not too abundant. Perhaps, with the passing of years and with more case history analysis, it will be relegated and subdivided as former nephron nephrosis, as to pathologic physiology and etiologic agents.

In a recent article Bashour and Winchell[1] presented 2 cases which apparently fit the so-called pattern of this condition; 1 case was questionably attributed to sulfonamide therapy, and the other followed a virus infection which was endemic in the area at the time. Their conclusions were: "The question that diffuse myocardial disease may be well related to any number of possible etiologic agents must be considered and therefore there was no real evidence to support a syndrome of post partal disease." Weiss[2] in 1939 stated: "Whether this type of illness is related to infectious, metabolic, or to a group of upper respiratory disease or Fiedler's myocarditis, is not clearly differentiated."

The possibility that some of the newer antibiotics, the hormones including desoxycorticosterone and the corticotropin group, may themselves be contributory to the etiology of this illness, must be kept in mind. The administration of the sulfonamide drugs in the past has been frequently accused, and there is no reason to believe that they may not have etiologic significance; it has been proved experimentally that a myocarditis mimicking this disease and identical in its pathologic findings may be produced by the administration of a sulfonamide in the experimental animal.

Read before the General Staff, St. Joseph's Hospital, Tampa, 1954.

Post partal heart disease is more common in the Negro race and occurs more frequently in the first pregnancy than in subsequent pregnancies.

Certainly, with the advent of many newer types of drugs and with more frequent sensitivity reactions, the physician must be alert in pregnancy cases to the possibility of an aftermath of a syndrome consisting of cardiac failure, with either a prolonged morbidity or an eventual fatality.

From a review of the literature and from the case presented, particularly emphasizing the great similarity of this group of cases, it appears there is most likely a syndrome idiopathic to pregnancy occurring post partum and not related to many of the known etiologic factors seen in this period, such as glomerulonephritis, toxemia of pregnancy, nutritional diseases such as beriberi, or other recognized heart diseases which tend to become aggravated toward the end of pregnancy.

History

The first reference to this type of illness occurred in an article by Virchow in 1870 describing a so-called idiopathic myocardial degeneration. It was not until 1933, however, when Williams[3] reported a large group of autopsied cases of so-called idiopathic myocarditis, with its symptoms of emboli, usually pulmonary, that the literature became more abundant and attracted the attention of the cardiologist and obstetrician. Saphir's review[4] of 240 cases of myocarditis in 1941 added further stimulus. The latest reference to this subject appeared in an article in the Annals of Internal Medicine, April 1954.[1]

Symptomatology

Earliest symptoms usually occur two to six weeks post partum.[5] Noted are a definite diastolic gallop rhythm; a small pulse volume, anasarca and left ventricular failure with pulmonary edema. Usually there is a diastolic hypertension; the heart appears grossly dilated. In approximately 25 per cent of the cases, pulmonary emboli occur. Arterial peripheral emboli occur less frequently. The electrocardiographic changes do not vary from day to day as with other myocarditis, and particularly common in all the cases reported in the

literature in which recovery does not take place within a short time is the presence of a persistent bundle branch block, usually with a predilection for the left bundle.

In a classical case, there is the formerly healthy woman, in whom towards the end of pregnancy or more accurately after delivery, there develops progressive myocardial failure without evidence of any other type of vascular disease, together with the symptoms and complications mentioned.

Differential Diagnosis

One must consider the heart failure associated with toxemia of pregnancy, but as a rule the heart involvement in toxemia occurs at the latest one week post partum. Beriberi, which, with the exception of its neurologic manifestations, pathologically resembles this illness closely, may be differentiated by its specific vitamin response. Rheumatic heart disease has more valvular involvement, and its response usually is different. Definite infections have not uniformly been proved or demonstrated to be of etiologic significance. So-called Fiedler's myocarditis resembles considerably this type of condition, but most authorities believe it to be of infectious etiology.[5]

Pathology

The pathologic findings may reveal either minimal myocardial changes or interstitial edema, parenchymatous degeneration or necrosis. Endocardial stasis thrombi in the ventricles are common. Fragmentation of muscle fibers is infrequently found. Other supplementary pathologic findings in addition to that of the heart are the peripheral arterial as well as pulmonic emboli and the infarction or congestive nephritis, but none of the typical findings of glomerulonephritis.

The laboratory features themselves are nonspecific. The blood, urine and chemistry findings are in no way different than those found in the usual congestive cardiac failure.

Prognosis

The average physician is probably not aware that such a syndrome or its equivalent exists. In the majority of the cases there is a benign course with recovery, and they are perhaps classified as bronchitis or influenza. In the remainder, the patients either become incapacitated for a long period of time or become permanent cardiac cripples; some terminate fatally. The mortality rate is 1½ per cent of all cardiac deaths associated with pregnancy.

A good prognosis is the rule if adequate care is administered when early signs of cardiac failure are noted, and complete recovery is evaluated before discharge.

Treatment

In the usual case there will be response to bed rest, digitalis and the customary procedures prescribed for cardiac failure. In the more difficult cases and those in which apparently recovery does not take place quickly, the disease is extremely refractory to the usual types of therapy, to digitalis, as well as to the vitamin B preparations, a factor of special significance in view of the supposed relationship to beriberi.

In view of the high percentage of embolic phenomena in this illness, anticoagulant therapy is a recent and valuable therapeutic adjunct and should be considered by those interested in pregnancy and in heart disease. Again, because of the possible relationship of this illness to the sudden increase of cardiac work following delivery, bed rest should continue for at least two to three weeks after all signs of edema and cardiac failure have subsided and the cardiac tones have returned to normal.

Report of Case

A 30 year old white woman was admitted to St. Joseph's Hospital on Nov. 11, 1952. The essential features of her admittance history were delivery of a baby spontaneously without difficulty on Aug. 28, 1952, two and one-half months previously; for the past six weeks a productive blood-tinged cough with slight fever, extreme weakness and diffuse perspiration; and for the past two weeks inability to sleep because of pronounced shortness of breath, palpitation of the heart, orthopnea and edema of the extremities.

The past history revealed that the patient had two other children delivered spontaneously without difficulty. There was no history of heart disease, rheumatic fever or any rheumatic diathesis. In general, prior to this incident, she had been in good health. Her husband stated that as far as he knew, there had been no prior evidence of shortness of breath or of heart trouble. Her examining physician stated that prior to delivery and after delivery, her heart was, as far as he could determine, perfectly normal.

The physical examination revealed a white woman, well developed, well nourished and acutely ill, appearing rather pale and in a state of semishock. The blood pressure was 92 systolic and 60 diastolic; she was moderately dyspneic and was more or less coughing incessantly. The temperature was 102 F., the pulse rate 132, and respiration 30. The heart was definitely enlarged to the left, with a pronounced gallop rhythm of the protodiastolic type at the apex with the second tricuspid sound moderately accentuated as well as the second pulmonic sound. There were no evidences of thrills or any definite murmur. The lungs were typical of pulmonary edema with a percussible increased dulness in the right base posteriorly. The liver was '2 fingers' enlarged and tender; the spleen was not palpable. There was no evidence of ascites. The extremities and back showed a moderate degree of dependent edema. Electrocardiograms (fig. 1) revealed a left bundle branch block on the day of admission and alsoon November 23 (fig. 2), when it was more complete than on November 11. The treatment administered consisted of the routine treatment for congestive heart failure, including digitalis, low sodium diet, oxygen, mercurials and anticoagulant therapy in the form of Dicumarol. In view of the persistent hemoptysis and roentgen findings, it was assumed that this patient had a pulmonary infarct.

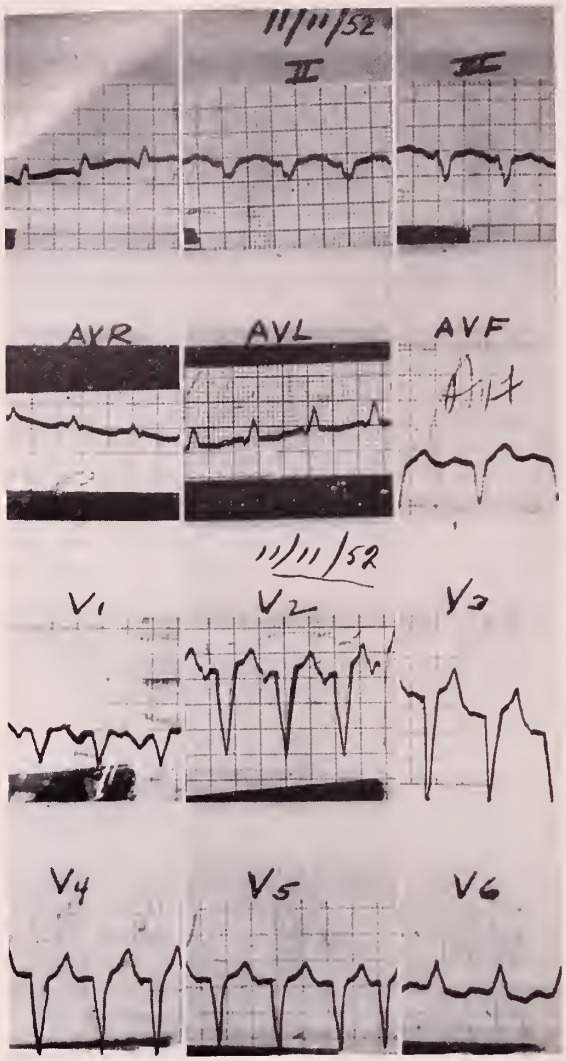


Fig. 1. — Electrocardiogram on November 11 revealed a left bundle branch block.

On admission the roentgenogram of the chest, portable film, was compatible with the diagnosis of moderate cardiac enlargement, infiltration of the base of the right lung and diffuse pulmonary congestion (fig. 3). On examination of the blood, the hemoglobin estimation was 12 Gm., the red blood cell count 3,850,000 and the white blood cell count 11,600, with a differential count of 75 per cent polymorphonuclears and 24 per cent lymphocytes. Urinalysis showed 1 plus albumin. The blood picture varied little throughout her entire stay in the hospital from November 11 to December 7, the date of her discharge.

Roentgenograms taken at intervals throughout this hospital stay showed on November 11 (fig. 3) cardiac enlargement and pulmonary congestion; on November 23 "slight clearing of vascular and perihilar infiltration, but persistent infiltration right base;" and on December 4 (fig. 4) "the heart to be of a globular shape, moderately enlarged, with evidence of peripheral residual right lateral pathologic change, interpreted as representing evidence of an old pulmonary infarct, otherwise complete clearing of the pulmonic pathology."

At the time of discharge on December 7, the patient was sitting up in a chair, was not dyspneic, felt perfectly comfortable and had been afebrile for about one week. She was given instructions regarding activities, digitalis and a low sodium diet. The diagnosis on discharge was diffuse myocarditis with left bundle branch block, congestive heart failure, and residual pulmonary infarct of the right lung.

Thereafter, I saw her on several occasions. She was ambulatory with restrictions, but the evidence of a gallop rhythm was always audible. An electrocardiogram in February 1953 revealed the same persistent bundle branch block. At that time she was able to attend church services and motion pictures, and to do the usual shopping without difficulty. There was no demonstrable evidence of cardiac congestion.

A roentgenogram (fig. 5) of the chest on April 3 demonstrated "the lung fields to be clear and essentially negative with the exception of the slightly enlarged globular heart and a slight blunting of the right costophrenic angle." There was no evidence of cough, hemoptysis or peripheral edema. She continued to take digitalis, and I attended her at approximately monthly intervals until the first part of September, at which time she became febrile and pulmonary congestion developed. This was the first recurrence of the pulmonic distress, or hemoptysis, since her discharge from the hospital some 10 months previously.

She was readmitted to St. Joseph's Hospital on September 14, at which time her blood pressure was 98 systolic and 80 diastolic, and the chest findings were essentially the same as on the previous admission — a gallop rhythm and pulmonary edema. There was no evidence of



Fig. 2. — Electrocardiogram on November 23 revealed a more complete left bundle branch block than on November 11, the day of admission.

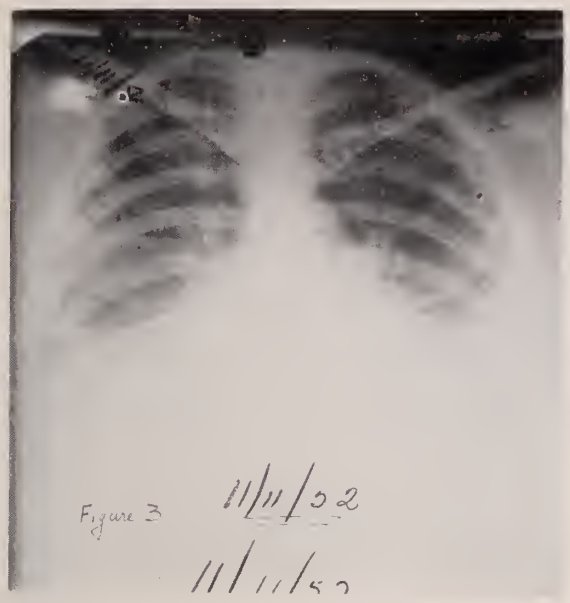


Fig. 3. — Roentgenogram of the chest at the time of admission was compatible with the diagnosis of moderate cardiac enlargement, infiltration of the base of the right lung and diffuse pulmonary congestion.

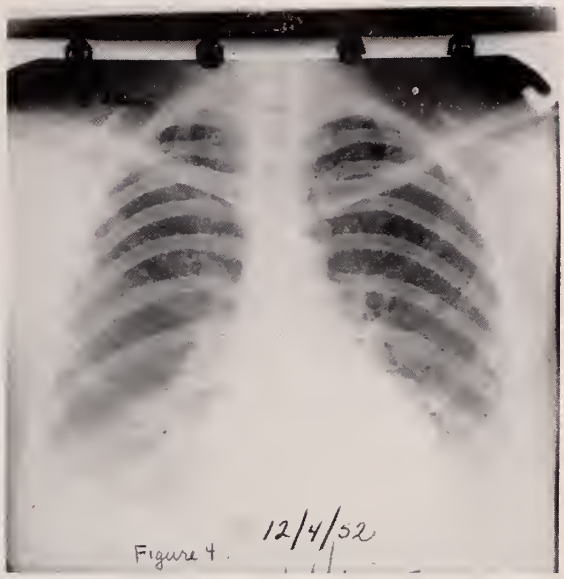


Fig. 4. — Roentgenogram of the chest on December 4 showed a globular-shaped heart, moderately enlarged, and gave evidence of peripheral residual right lateral pathologic change, which was interpreted as representing evidence of an old pulmonary infarct. Otherwise, clearing of pathologic pulmonic changes was complete.

a pericardial friction rub or of a murmur. The heart seemed to be beating exceptionally vigorously against the chest wall. There was extreme tenderness under the left breast area. The edge of the liver was only slightly palpable and tender; there was no evidence of ascites or splenic enlargement.

The diagnosis on admission was diffuse myocarditis with multiple pulmonary infarctions and cardiac failure. The source of the pulmonary infarcts was thought to be associated with a damaged myocardium probably secondary to pregnancy if the history and examinations prior to this last pregnancy were correct. An electrocardiogram (fig. 6) revealed a similar persistent left bundle branch block.

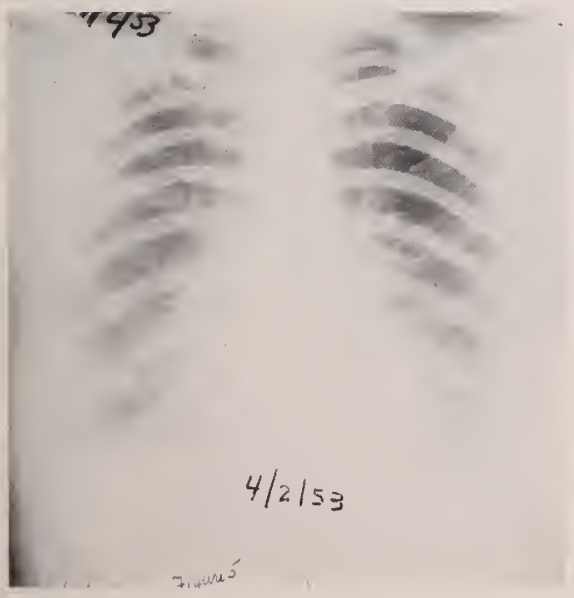


Fig. 5. — Roentgenogram of the chest on April 3, 1953 showed only the slightly enlarged globular heart and a slight blunting of the right costophrenic angle. The lung fields were entirely clear.

Roentgenograms of the chest on September 16 (fig. 7) and 30 (fig. 8) revealed gross cardiac enlargement and pulmonary congestion and probably multiple infarcts, particularly of the lower lobe of the right lung. The temperature on admission to the hospital was 102 F., pulse rate 106, and respirations 24. The temperature curve during this her last hospital stay remained markedly elevated, going as high as 104 F. on several occasions and with chills, frequently once or twice daily. The electrolyte balance on admission was essentially within normal limits. The white blood cell count was 34,600 with 86 per cent polymorphonuclears, 9 per cent lymphocytes and 5 per cent monocytes; the platelets appeared decreased. The hemoglobin was 12.3 Gm.; the protein bound iodine was 4.9 micrograms per hundred cubic centimeters, which was within normal limits. The urine was essentially normal. L. E. studies, peripheral and bone marrow, as well as two blood cultures gave negative results. The sedimentation rate on two occasions was not elevated.

Medication consisted of the usual therapy for cardiac failure, in addition to large doses of antibiotic therapy, penicillin, the "mycins" and anticoagulants. In view of the failure of response in this case, she received a week's trial of the corticotropin hormones.

A surgeon was called in consultation to see if he had anything to offer as to whether there might be phlebothrombosis in the legs or some other source of the pulmonary emboli. It was his conclusion, however, that "the whole problem was one of a cardiac condition with complications." He could see no indication for surgical intervention.

During this period of hospitalization, the course was progressively downhill: increasing hepatic enlargement, anasarca, cardiac failure, pulmonary edema and an increasing degree of hemoptysis until the time of death. There was, at no time, evidence of peripheral petechiae or hemorrhages in the skin or conjunctiva. She expired on October 2, one year and five weeks after delivery.

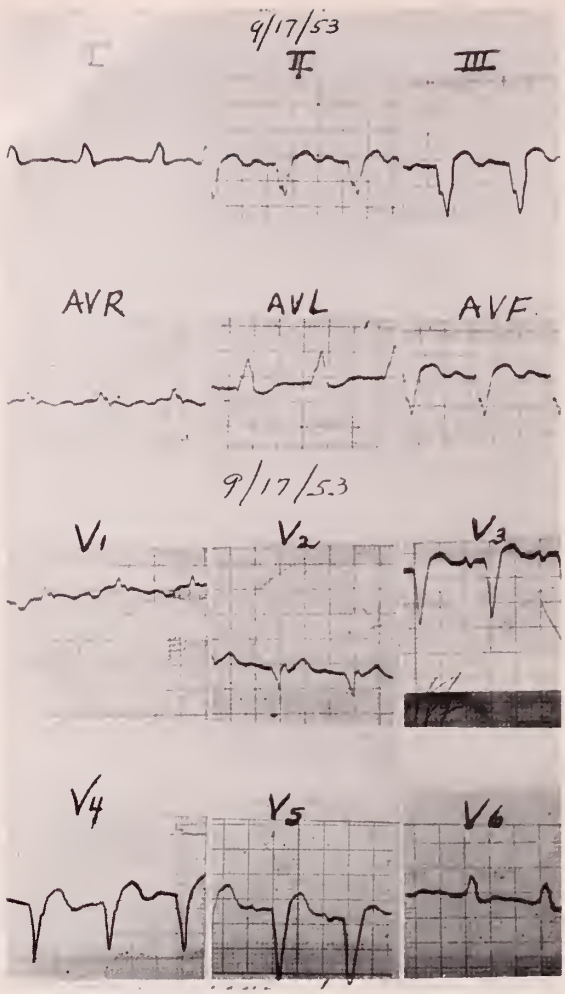


Fig. 6. — Electrocardiogram on September 17 showed persistent left bundle branch block similar to that on admission.



Fig. 7. — Roentgenogram of the chest on September 16 showed gross cardiac enlargement and pulmonary congestion and probably multiple infarcts, particularly of the lower lobe of the right lung.

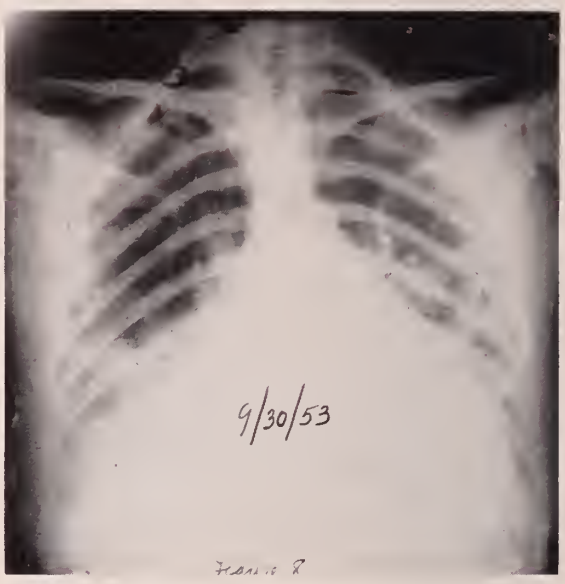


Fig. 8. — Roentgenogram on September 30 showed findings of September 16 unchanged.

Throughout the entire illness, the heart did not demonstrate any specific murmurs or pericardial friction rub, but the same gallop rhythm that was audible with the first examination persisted throughout.

The differential diagnoses considered were subacute bacterial endocarditis, Libman-Sacks syndrome, pericarditis with effusion, and congential heart disease with the possibility of a superimposed bacterial infection.

The slides (microscopic) together with the case history were sent to two independent groups of pathologists in larger group clinics, and both groups concurred independently in the diagnosis of post partal myocarditis.

Autopsy Report. — In summary, the findings at autopsy, performed by Dr. Robert J. Davis, were:

1. Myocardial hypertrophy (450 Gm.) and dilatation (severe and generalized).
2. Multiple microscopic foci of degeneration and fibrosis in the myocardium particularly involving the interventricular septum and the subendocardial tissues of the left ventricle (figs. 9 and 10).
3. Mural thrombosis of the myocardium of both sides of the heart.
4. Thrombosis of the right ovarian vein and plexus as well as the periuterine veins and sinusoids.
5. Multiple pulmonary emboli with infarcts.
6. Small infarcts in the left kidney.
7. Centrolobular congestion and necrosis of the liver.
8. Acute focal esophagitis and ulceration.
9. Two accessory spleens.

Dr. Davis commented: "The etiology of the myocardial lesions remains obscure. I believe the myocardial damage is the result of anoxia due to repeated pulmonary emboli. The small coronary arteries with emboli may have played a role in extending the lesions."

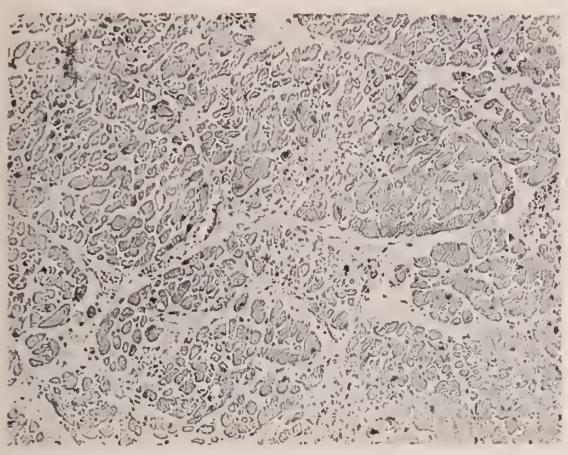


Fig. 9.—Specimen showing multiple microscopic foci of degeneration and fibrosis in the myocardium particularly involving the interventicular septum and the subendocardial tissues of the left ventricle. X 100.

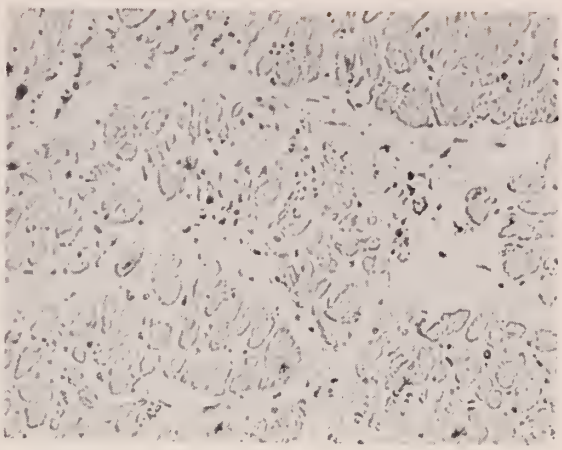


Fig. 10.—Similar findings. X 400.

Summary

A case is presented in which a cardiac condition occurred post partum. More clinical investigation is necessary, but obstetrician and cardiologist may profit from and clarify this diagnosis by being post partum myocarditis "conscious."

References

1. Bashour, F., and Winchell, P.: Post Partal Heart Disease, A Syndrome?, Ann. Int. Med. 40:803-808 (April) 1954.
2. Weiss, S.: Diseases of Heart and Aorta Which Are Not Well Recognized, Med. Clin. North America 23:1323-1344 (Sept.) 1939.
3. Williams, P. F.: Causes of Post Partal Deaths, Weekly Roster and Medical Digest 27:7, 1933.
4. Saphir, O.: Myocarditis; General Review, with Analysis of 240 Cases, Arch. Path. 32:1000-1051 (Dec.) 1941.
5. Melvin, J. P. Jr.: Post-partal Heart Disease, Ann. Int. Med. 27:596-609 (Oct.) 1947.

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Practical Management of Nasal Allergy

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PENSACOLA

During the past two decades there has been a great degree of emphasis on specialization. This is particularly noteworthy because the primary object of specialization is to increase basic knowledge and skill pertaining to individual areas of the body. It is apparent that the specialist not only should have an abundance of knowledge pertaining to the individual area of the body with which he is primarily concerned, but as well should appreciate its inter-relationship with the entire body functioning processes, namely, how it influences the body and how the body influences it. This appreciation is essential if treatment of any sort is to be satisfactory.

This presentation on the practical management of nasal allergy purposes to make clear that nasal allergy is merely a local manifestation of a general systemic disease, which affects the entire organism in various degrees. Ultimate treatment must be instituted to the entire organism to insure a satisfactory result.

Read before the Eye, Ear, Nose and Throat Hospital Alumni Association, New Orleans, April 5, 1954.

Diagnosis

In the nose there are many conditions which may simulate allergy or even coexist with allergy. The nose, with its abundance of erectile tissue and autonomic nerve supply, is capable of a wide variety of moods and disorders. Allergy, infection, endocrine deficiency, and emotional disorders attack it frequently and sometimes may operate in unison. One should be able to decide at a glance whether or not a patient who is already in the throes of one condition is coming down with another.

More so than in any other disease, history is the most essential factor in arriving at a satisfactory diagnosis. If the history is satisfactorily developed, it will be evident that 50 to 60 per cent of allergic persons have some positive family background of allergy, especially if one considers the chronic catarrhs and sinus diseases of the past decades.

When allergic etiology is suspected, the clinician must take a detailed personal history of the patient dating back to childhood and inquire as to colic regurgitation, indigestion, eczema, and hives. Many of these episodes are normally forerunners of allergy.

Next, one must pinpoint the episodes of discomfort experienced by the patient as to time of year and time of day, and evaluate environmental and occupational factors, which may be the primary or secondary etiologic factors in the disease process.

The examination of the nose in uncomplicated allergy shows pale, boggy turbinates, polyps that are bilateral or multiple, if the process is of long duration, and sinuses that have some uniform haziness on transillumination. Many allergic noses may appear grossly normal to the examiner, and it is here that a simple and easily performed diagnostic aid may be utilized, namely, nasal cytology.

About half of the persons who complain of a chronic postnasal drip have a normal-looking nose. If one takes the trouble to examine the nasal secretions from the nostrils, eosinophils will be found in about 5 per cent, and a normal clear mucus devoid of leukocytes in about 15 to 20 per cent. When there is positive indication of ininflammation in the nose, one may find that approximately 80 per cent of the smears contain neutrophils and that 30 per cent contain eosinophils. A positive finding of eosinophils is of significance, but the absence of eosinophils does not rule out the condition. In the majority of cases there is some evidence of infection, usually subclinical, and not a little evidence of allergy, which seems to suggest considerable overlapping in a great many instances. The Hansel stain makes cytologic examination a simple office procedure.

Management

If, after the history and the nasal cytology, one is led to believe that there is a probability that the primary condition is an allergic one, then indicated skin tests should be performed as a confirmatory measure and as a guide to specific treatment. I reiterate the phrase "indicated skin tests." It is rarely necessary for the otolaryngologist to have to perform more than routine tests for inhalants and common foods. It is the consensus of the majority of allergists that skin tests for foods are at best 50 per cent accurate and are relatively unimportant except in urticaria and childhood and adult eczema. Individual food tests and subsequent dietary control may be employed if food is indicated as a large factor in the patient's disability. Usually this information is obtained primarily from the history. After the performance of indicated tests, specific treatment may then be instituted. This will consist of desensitization to the offending allergens, and avoidance and elimination, if feasible, of the offending agents.

Specific allergic management does not preclude the institution of proper management of coexisting nasal infection, or sinus infection. These infections are handled in the usual manner and in many instances must be controlled before any degree of success can be obtained with allergic management. Obstructions to adequate ventilation and drainage of the nasal airway must be removed and coexisting underlying infection eliminated. The removal of infected tissue represents an important phase of preventive allergy.

In nasal allergy of long standing with underlying secondary infection, in many instances specific allergic therapy will not be successful unless, at the same time, some form of bacterial desensitization is incorporated with the specific allergic management.

In many instances bacterial invasion will appear to be the activating factor in an allergic disorder. The use of indicated antibiotics definitely shortens the duration of disability in many instances and definitely shortens the duration of the subsequent allergic episode. Many authors have reported extremely beneficial results from the use of autogenous and stock vaccines in the treatment of intrinsic and extrinsic asthma. It is reasonable to anticipate equally beneficial results in allergic rhinitis with associated intrinsic factors in the pharynx or sinuses. I have utilized stock and autogenous vaccines routinely during the past four years in cases of nasal allergy that were precipitated or exacerbated by superimposed infection. Nasal cytology repeated at infrequent intervals will give one an index as to the need for this form of treatment.

It should be fairly obvious to this group that a frequent aggravating factor in nasal allergy is medication topical in nature which the patient in many instances has administered to himself over a long period of time prior to reporting to the office. It is not uncommon to have cases that appear to be nasal allergy due purely to topical vasoconstrictors, Privine being one of the most frequent offenders that I personally have encountered; however, any type of nasal medication, if used over a long period of time, may in itself be initiating and a contributing factor in nasal allergy. Medicine taken internally over a long period of time likewise may be a perpetuating factor in nasal allergy.

It is routine practice in my office not to attempt to perform any diagnostic skin tests on patients on their initial visit to the office if underlying nasal allergy is suspected. The usual procedure is to eliminate all medication which the patient has previously used to control his condition; secondly, measures are taken at the initial visit to attempt to improve the general nutritional status of the patient. These consist of supplementary vitamins, and protein hydrolysates as supplementary feedings especially in malnourished children. If the initial history contains many episodes of indigestion, or gastrointestinal upsets, and so-called food intolerances, a gastric analysis is obtained. Many of these patients are deficient in free hydrochloric acid, and their alimentation can be greatly improved by giving Normacid before meals in appropriate dosage. All intranasal medication is discontinued, and some form of vasoconstrictor, such as syrup of Ephedrol, Propadrine, or Dexedrine is prescribed to be taken internally, while the nasal tissues are given a so-called period of rest. Sedorzyl, a preparation containing iodine and propadine, has proved to be most efficient for this purpose in all age groups.

Measures are taken to insure the patient a reasonable period of rest at night, and sedation is prescribed. After the patient has been on this regimen for a week or 10 days, he is asked to report back to the office. In many instances, there is a great improvement in the underlying nasal allergy. This initial period of placing the tissues at rest and an attempt to build up the nutritional status of the body tissues will greatly shorten the subsequent therapy in many cases, and also tend to eliminate any false positive skin reactions. As has been indicated previously, there are many conditions which may coexist with nasal allergy which will produce essentially the same conditions as nasal allergy. Unless these are controlled, the underlying treatment will be of little avail.

Psychiatric Aspects

The recent literature is voluminous on psychiatric aspects of allergy and on psychotherapeutic management of allergy. One outstanding conclusion can be drawn, namely, psychiatry has gone far in the understanding of these patients but has yet done far too little in the way of relief. Basic emotional disturbances tend to make the patient less resistant to provoking allergens. From these various studies, one may conclude that the anxious allergic patient will usually do well on some form of sedation; the depressed patient is helped by preparations such as Dexamyl; the hostile patient should receive minimal doses of drugs which may be stimulating; and the euphoric and phobic patient may require psychotherapy. The type of drug employed should be correlated to the immediate emotional state of the patient.

Deficiency Factors

Endocrine dysfunction is not an unusual accompaniment of allergic disorders.

Hypothyroidism probably does not occur any more frequently in persons with an allergic condition than in the whole population. Many clinicians only recognize hypothyroidism when it is most apparent, and unfortunately this is frequently the only type about which information is taught or written. Hypothyroidism occurs most often in subclinical forms of mild degree, and these states can occasionally last temporarily and not be recognized. A clinical awareness of this possibility and having it confirmed by a determination of the basal metabolic rate makes satisfactory therapeutic results which would not otherwise be obtainable. Thyroid substance has some universal systemic effects; it is calorigenic, sympathicotonic, dehydrating, and appetite-stimulating. Subclinical hypothyroidism is far more prevalent in malnourished and physically retarded children than is generally appreciated. The dosage of thyroid employed in subclinical hypothyroidism may have to be raised to what is normally considered excessive levels, for the tissues not being in great need are not avid for the extract. Thyroid substance should be used intermittently as long as there is noticeable clinical response.

Deficiencies of androgens and estrogens may require replacement if after a reasonable period

of time one does not secure the anticipated results from proper allergic desensitization. These deficiencies may be anticipated if one will be aware that allergic disorders occurring after the third decade may have some concomitant endocrine dysfunction, which may be subclinical and is just as prone to occur in either sex. It should be emphasized that no form of endocrine supplemental therapy should be undertaken, especially of the estrogen and androgen variety, or a combination of the two, without a thorough evaluation to rule out any possibility of underlying malignant disease in the reproductive organs. This form of therapy is definitely not indicated when one encounters a positive background of carcinoma in the patient. Utilization of a combination estrogen-androgen oral therapy, Gynetone Repetabs, has proved most efficacious in my hands. It affords the patient an improved muscular tonus and sense of well-being without the undesirable effects of either preparation utilized alone. Appetite and mental alertness are improved especially in the elderly patient, and nasal symptoms are definitely improved.

Nonspecific Measures

Nonspecific measures that may be employed in nasal allergy which are in vogue today consist of therapy with antihistaminics, and also with ACTH and cortisone, the latter being employed in nose drops and injected into the turbinates. These drugs are definitely not curative. The corticotropins produce pronounced systemic changes, and the periods of relief afforded by their utilization are most uncertain. Allergic reactions to these agents have been reported, as well as production of major psychotic episodes. Current opinion does not favor the systemic usage of the corticotropins in nasal allergy.

Submucosal coagulation of the turbinates and submucosal resection of the inferior turbinates have been reported as favorably influencing the course of clinical allergy by competent clinicians. In long-standing cases one can appreciate the stasis and resultant hypertrophy that will result, and in properly selected cases coagulation may be a useful adjunct to treatment. Submucosal resection of the inferior turbinates is utilized when the encroachment on the airway is produced by the enlarged bony component of the inferior turbinate. My personal experience has not included this procedure.

Conclusion

Needless to say, all of these approaches to the treatment of allergy have helped to allay certain symptoms and therefore have important therapeutic value; however, they have not helped resolve the basic vexing problem of allergy. The contributions of therapy based on the allergen antibody concept have given a profound insight into the fundamental nature of allergy. It is therapy that is based on this concept that offers the greatest hope for good and lasting results.

In conclusion, I wish to reiterate that the treatment of allergy must be viewed from a constitutional and preventive standpoint. It entails a search for all offending substances, and their elimination or reduction, and a definite program for building up an immunologic tolerance for the offending allergens. Nutritional, psychogenic, and endocrine factors must be controlled if therapy is to prove efficacious.

References

Abramson, H. A.: Psychodynamic Pharmacology of Treatment of Asthma. J. A. M. A. 150:569-574 (Oct. 11) 1952.

Alexander, H. L.: Nonallergic Bronchial Asthma, Postgrad. Med. 10:117-121 (Aug.) 1951.

Feinberg, S. M.: Drug Allergy — Some Clinical Immunological Aspects, Ann. Allergy 10:260-269 (May-June) 1950.

Hansel, F. K.: Clinical Allergy, St. Louis, C. V. Mosby Company. 1953.

Hansel, F. K.: Methods of Immunization Employed in Treatment of Sinusitis, Ann. Allergy 10:131-135 (March-April) 1952.

Hilger, J. A.: Common Ground of Allergy, Autonomic Dysfunction and Endocrine Imbalance, Tr. Am. Acad. Ophth. 57:443-446 (May-June) 1953.

Reilly, W. A.: Hyperthyroidism in Pediatric Allergy, Ann. Allergy 11:143-145 (March-April) 1953.

Semenov, H.: Pathology of Nose and Paranasal Sinuses. II. Rhinitis and Sinusitis, Tr. Am. Acad. Ophth. 57:399-440 (May-June) 1953.

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Eighty-Second Annual Meeting
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Auricular Septal Defect in a Seventy Year Old Patient

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While a moderate degree of longevity, approximately 40 years, can be expected in congenital atrial septal defects, such a defect in a 70 year old patient seems unusual enough to be worth reporting.

The patient was a white woman presenting the classical appearance of the gracile habitus, being 5 feet 1 inch in stature, of frail build and bony structure, and having gray hair and delicate texture of skin. Her record dated back to 1940, at which time she first visited the outpatient cardiac clinic. The symptoms at that time and up to the time of her death were those of congestive heart failure. There were numerous hospital admissions, but she was ambulatory most of the time. Up to the time of the last admission she was in the classification of grade 2 to grade 3 decompensation. Digitalis, mercurial diuretics and low sodium diet along with restriction of physical activity gave the patient relatively satisfactory results during the 14 years she was under observation.

Clubbing and cyanosis were notably absent, but acrocyanosis was noted from time to time. She died during a course of bronchopneumonia, a frequent complication of auricular septal defect.

Along with the classical findings of cardiac decompensation there was slight deformity of the left wall of the chest. Auricular fibrillation was present constantly since the first observation in 1940.

The blood pressure was in about the range of 122 systolic and 65 diastolic most of the time. The low blood and pulse pressures, usually present in such cases, were not noted. The roentgen findings were typical, consisting of great enlargement of the right auricle and right ventricle, prominent pulmonary conus, absence of aortic knob and increased hilar shadows. The heart murmurs consistently showed accentuation of P2. A diastolic murmur heard over the left sternal border at the level of the third intercostal space was present along with grade 2 systolic apical murmur. Rales were present in both lung fields posteriorly at the base.

The electrocardiograms over 14 years showed little change. Along with persistent auricular fibrillation, there was evidence of a right bundle branch block.

Autopsy revealed enlargement of the right auricle of considerable degree, hypertrophy and dilatation of the right ventricle, great enlargement of the pulmonary artery and a relatively small aorta. An oval opening between the two auricles measured 3.3 by 2.8 cm. There was no evidence of mitral or aortic valvular disease.

Summary

A fatal case with autopsy is reported in which a 70 year old white woman with congenital interatrial septal defect was observed for 14 years. All classical findings were present with the exception of the low pulse pressure. Arachnodactylia was not present.

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The Journal of the American Medical Association is limiting its Current Medical Literature section. Thus, our main source of information on articles written by our members has been greatly curtailed.

Changing Trends in the Surgical Treatment of Pulmonary Tuberculosis. By Hawley H. Seiler, M.D. South. M. J. 47:627-633 (July) 1954.

As a direct result of the remarkable advances made in the field of thoracic surgery in recent years, pulmonary resection is now accepted as an essential part of any well coordinated therapeutic program in the treatment of pulmonary tuberculosis. In discussing this change of concept regarding the treatment of this disease, Dr. Seiler points out that such procedures as pneumonectomy, lobectomy, segmental and wedge resection, and local excision today take precedence in most instances over collapse measures including thoracoplasty. Formerly used extensively, the collapse procedures continue to be used occasionally, but their role is a diminishing one.

This author comments upon such factors as the streptomycin era, improved anesthesia, and the aggressiveness of thoracic surgeons, with greater boldness, more extensive surgery and the use of new technics and refinements resulting. He cautions, however, that surgery is merely an adjunct in the over-all therapy in this disease and must be combined with the basic principles of treatment, namely, rest, sanatorium care and antituberculous drugs. Also, of extreme importance is the proper timing of surgery as related to the over-all therapeutic regimen. He advises an open mind on the subject of therapy as present concepts are constantly susceptible to change as a result of the advent of newer drugs and newer surgical methods.

Renal Function after Complete Bilateral Ureteral Obstruction Following Colporrhaphy. By Benedict R. Harrow, M.D. Am. J. Surg. 87:842-850 (June) 1954.

A case is described in which complete bilateral ureteral obstruction occurred following gynecologic surgery. It is believed to be the ninetieth such case reported in the English literature and the fourth in which such an episode followed an anterior colporrhaphy. Also, it is the fourth proved case of complete ureteral obstruction due to kinking and the only reported case in which roentgenograms demonstrated the kinks. Of particular interest was visualization of iodide in a kidney completely obstructed for 13 days; obstruction persisted for a period of 23 days, but after four months the pyelogram was normal. The author discusses the experimental and clinical data of renal function and the low secretory pressure continuing in hydronephrosis during complete obstruction. He concludes that the main mechanism is glomerular filtration and urothelium reabsorption.

This case emphasizes that kinking alone can produce a complete obstruction which may last for several weeks and thus requires early surgical intervention to relieve the anuria. In making an accurate diagnosis in bilateral ureteral obstruction the use of the occlusion catheter is regarded as invaluable. Bilateral nephrostomy or intubated ureterostomy rather than deligation is recommended as the treatment of choice even after vaginal surgery, and insertion of ureteral catheters in secondary colporrhaphy or in anticipated difficult abdominal surgery is strongly advised as a preventive measure.

Formation of a Labile Pigment in Rabbit Ova During Histochemical Demonstration of Succinic Dehydrogenase. By Alvan G. Foraker, Sam W. Denham, and Dorothy D. Mitchell. Science 117:449-451 (April 24) 1953.

These authors previously described the histochemical demonstration of succinic dehydrogenase, one of the vital respiratory enzymes. They demonstrated the activity of this enzyme in ovaries of rabbits injected with urine from pregnant or nonpregnant women. As a further investigation, reported here, they similarly processed additional blocks of ovaries of 3 rabbits receiving no urine injections in NT with succinate.

They conclude that it is reasonable to assume that the presence of labile reddish pigment within the rabbit ova as the sole manifestation of succinic dehydrogenase may signify the presence of a localized lesser degree of activity of this enzyme than found in certain other components of the ovary.

The Art of Clinical Radiology. By Joshua C. Dickinson, M.D. Am. J. Roentgenol. 73:1-4 (Jan.) 1955.

In his President's Address delivered before the Fifty-Fifth Annual Meeting of the American Roentgen Ray Society in Washington, D. C., last September, Dr. Dickinson reviewed the early history and technical progress of radiology. He then made a strong plea for the application of the art of clinical medicine in the practice of radiology. He would have today's radiologist become a real clinician, magnifying the role of the early radiologists, who "were keen clinicians who had the God-given ability to make accurate observations and interpret their findings in terms of pathology."

He added an earnest appeal for a program of resident training in radiology broad enough to include ample opportunity for adequate training in a proper physician-patient relationship as well as in research and in the mastering of complicated gadgets. It was his opinion that the development of the concept of the patient in teaching, rather than the disease, is a major aim in medical education today deserving every encouragement in radiology just as in other branches of medicine. He sought to impress upon the fledgling radiologist that upon certification by the American Board of Radiology he has yet to prove himself capable of being regarded as a competent consultant in clinical radiology.

Observing that clinical medicine has matured, he continued in conclusion: "In clinical Radiology at its best we care for the patient. The highest possible standards of scientific precision are no deterrent to compassion or any of the other generous gifts of the healer. The goal is cure through understanding. In the words of Osler, 'The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will exercise equally with your brain.' The compensations are abundant and abiding. . . . The challenge is greater today than ever before, . . . Let us then cultivate the art of clinical Radiology wholeheartedly and nurture it properly so that it may fulfill the great promise which it holds for the future."

Pulmonary Resection in the Treatment of Blastomycosis. By Howard A. Buechner, M.D., Augustus E. Anderson, M.D., Lawrence H. Strug, M.D., John H. Seabury, M.D., and J. Winthrop Peabody Jr., M.D. J. Thoracic Surg. 25:468-479 (May) 1953.

The 2 cases here reported are believed to be the first to appear in the literature wherein lobectomy was employed in the treatment of pulmonary blastomycosis. One case, with a discrete nodular lesion, is the first to be reported in which resection alone effected an apparent cure. The excellent result in this case suggests that pulmonary resection should be strongly considered in the therapy of some cases of blastomycosis. In the second case, with acute progressive disease, the patient suffered an early relapse. The prompt recurrence in this case seems to indicate that resection alone does not represent wise or suitable therapy in dealing with intense, poorly localized, progressive blastomycotic lesions.

The authors point out that pulmonary blastomycosis must be differentiated from bronchogenic carcinoma, which it may simulate closely. In their opinion the management of blastomycosis should be similar to that of pulmonary tuberculosis. With this point of view in mind, they suggest that the combined use of drug therapy (diamidines, iodides, and vaccine) and resection might offer more favorable results in pulmonary blastomycosis, just as streptomycin and para-aminosalicylic acid combined with surgery have improved the prognosis of tuberculosis.

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The Journal of the Florida Medical Association

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"A.M.A. Seal" Disappears Councils Expand Programs

The issuance of seals or emblems by any part of the American Medical Association has been discontinued. This recent change in policy of the A.M.A.'s product-evaluating councils is of wide interest to physicians and to the laity, for over the years the councils have become well known for this phase of their activities, better known probably for this work than for their other efforts in the broader educational aspects of collecting, digesting, and disseminating medical information. In fact, the seal or acceptance program has appeared to dominate their activities because of its dramatic effect and the prominence given it.

For many years these evaluating councils have provided leadership in the evaluation of products used by physicians and to some extent by the public. Since 1905 the Council on Pharmacy and Chemistry has evaluated and reported to the medical profession on drugs and related therapeutic procedures. The Council on Physical Medicine and Rehabilitation, formerly the Council on Physical Therapy, has gathered information since 1925 on therapeutic and diagnostic devices. The Council on Foods and Nutrition began evaluating nutritional claims and food products in 1929, and since 1948 there has been a Committee on Cosmetics. Over the years these councils have awarded seals to manufacturers and distributors of drugs, devices, and cosmetics complying with the rules for such acceptance. Also, an advertising emblem has been available for products not coming within the scope of a council. "Accepted for advertising in the publications of the American Medical Association" and "Accepted for advertising in Today's Health" are statements, often in the form of an emblem, which have become familiar to the public.

Because of the great demand caused by the tremendously and broadly expanding horizon in diagnostic, curative, and preventive medicine, the Board of Trustees of the American Medical Association and the councils plan to devote more time to this important phase of their work and to

increase this work to match the need. While the acceptance program has been useful through the years, the need for it has decreased as laws have been enacted and manufacturers have assumed more and more their share of responsibility in marketing worthwhile products. So the "A.M.A. seal" and the emblem are relegated to the past.

How will the expanded programs of the councils render more service to the profession and the public? The councils will issue reports promptly and frequently on what is new in diagnostic, curative, and preventive medicine in their respective fields; periodically they will review the status of agents and technics; they will develop basic standards for classes of goods; and they will undertake educational efforts to insure as much as possible the utilization of the information they gather, digest, and evaluate. Gathered from manufacturers, researchers, published medical literature and other sources, this information will be made available in The Journal of the American Medical Association. Books or booklets in which such information can be presented handily and usefully also will continue to be issued.

Will the advertising standards for the publications of the American Medical Association be lowered by this change in emphasis in the councils' programs? Although the long familiar seal will not be seen, there is every assurance that basic principles will continue in effect and that the best interests of the members will be served. The councils will issue statements on their programs and at the same time make available details on the principles of advertising for A.M.A. publications. Their long experience enables them to provide the leadership required to meet the extraordinary challenge all of medicine encounters today because of the swiftly moving pace of medical knowledge and the eagerness with which physicians and the public await it. Both doctors and patients stand to benefit.[1]

1. A. M. A. Councils Expand Their Programs, J. A. M. A. 157:664-665 (Feb. 19) 1955.

Proceedings of Eighty-First Annual Meeting Scheduled for Publication In the June Issue

Plea for Spiritual Rebirth Within Medicine

Among more than 100 papers presented at the A.M.A. Clinical Meeting in Miami, one with the intriguing title, "The Man Behind the M.D.," was on a subject somewhat different from the usual papers given at medical meetings. Dr. Julian P. Price of Florence, S. C., an A.M.A. trustee, delivered the paper before the pediatric group and used the opportunity to urge physicians to join in a spiritual rebirth within medicine.

In appraising the health of the country, Dr. Price expressed the belief that the physical and mental health of our nation is relatively good, but that there is evidence of spiritual disease. "Since the disease is spiritual," he added, "the treatment must also be spiritual."

The symptoms, he observed, were not hard to find. Among them he named "laxness of morals in our national government in recent years . . . the hold which organized vice has upon legislative and social life . . . increase in crime in our teenage population . . . bribery and unethical conduct in amateur athletics . . . the mad search for pleasure which causes our people to spend four times as much for beverages as they do for religious and welfare activities. . ."

Warming to this subject which had been milling around in his mind for years, Dr. Price called upon his fellow physicians to combat this "disease" by taking part in government, devoting particular interest to public education, working with boys and girls and charitable and philanthropic organizations, and having healthy, happy homes of their own.

"The only remedy," Dr. Price concluded, "which is of any avail — and to this history bears testimony — lies in a change of heart. It is my sincere belief that the greatest need of our country today — and of our profession — is a spiritual rebirth, a return to God and to his eternal principles. And the rebirth must come in the heart of the average citizen — and in the heart of the average doctor of medicine."

This address won prominence on page one of a Miami newspaper and furnished the basis of editorials in the Nashville Banner and several other newspapers. One commentator observed that from a newspaper standpoint Dr. Price's talk caught on like wildfire and really rang the bell with the public. And why not with the profession, too? It got down to bedrock.

Men Need Slimming Motive

One key to progress against the major health problem of obesity doubtless lies in the discovery of a motivating force sufficiently compelling to make men "strive for slimness" as women have. Be it social, attuned to fashion or otherwise, such a motive might halt the present trend. This trend promises to make obesity even more of a problem in the future than it is now. The increase in total population and the increase in proportion of older persons, since obesity is more frequent at older ages, form the basis for the dim outlook for the future unless the trend is reversed. These views were expressed by Dr. James M. Hundley of the National Institutes of Health, Public Health Service, Bethesda, Md. in an address at the Weight Control Colloquium at Iowa State College recently.[1]

This eminent nutritionist said that almost twice as many men as women suffer from obesity. The picture is reversed, however, among the Negroes, with an especially high prevalence of overweight among the women.

Persons who are overweight are subjected to definite health hazards. Dr. Hundley cited studies showing that overweight persons are more likely to have not just one but a combination of serious chronic illnesses, such as heart disease and diabetes, high blood pressure and arthritis, high blood pressure and disease of the gallbladder, and heart disease and gallbladder disease. While it is difficult to prove that overweight is the cause of these diseases, he observed, nevertheless physicians have noted improvement in diabetes and in hypertension when weight has been reduced.

Methods of controlling obesity are "crude," he declared, "but progress can be made." A major step forward would be the discovery of a motivating force sufficiently powerful to sway the masculine mind toward slimness. Any physician who could uncover such a motive would win an enviable place for himself in medicine and in the hearts of his obese fellow men. It is noteworthy that one of the three most popular motion pictures shown at the A.M.A. Clinical Meeting in Miami was "Management of Obesity" by Dr. Norman Jolliffe of New York City.

1. Motive Needed to Make Men Try to Lose Weight, Science News Letter 67:94 (Feb. 5) 1955.

Physician's Role in Care of Aged and Chronically Ill

Medical progress saves the lives of countless patients today who in days past would have become the victims of infectious diseases and other disorders now under control. In consequence, the number of those who become old and finally ill and debilitated steadily mounts. Literally millions of patients with long-lasting, poorly understood diseases and with crippling disabilities need care requiring special skills and concern not only with the disease itself but also with the patient's personal problems. Thus does progress multiply the many problems created by chronic illness and by the varying needs of aged and debilitated patients.

Intelligent preventive medicine, employing all the knowledge available today, is able to ward off some of the chronic diseases and some of the complications of aging. This point of view, realistic though it is, nevertheless is ignored far too often in the opinion of the noted research physician and medical teacher, Dr. Freddy Homburger. In his book entitled "The Medical Care of the Aged and Chronically Ill," published in mid-March and reviewed elsewhere in this Journal, he observes that the attitude of many physicians and of today's medical students when faced with the aging patient is often one of resignation and lack of interest. Yet these patients present some of the most rewarding opportunities for preventive as well as curative medicine.

The role of the modern physician in the management of chronic illness is tremendously challenging. A person turned 80 has a life expectancy of more than 5 years. Should medicine not make these years as agreeable as possible? The patient over 50 with aches and pains may have senile osteoporosis. Will he be a shriveled, weak, unhappy person in a few years, or a well-preserved, active one? That will depend on whether the physician knows how to handle this problem and does so, or merely dismisses the situation as just another price one has to pay for growing old. Too, it is just as bad medicine to give pills for dysfunctions arising in older persons because they feel lost, useless and lonely as it is poor medical judgment not to seek out those difficulties responsive to therapy, simply because a person is old. Dietary readjustment, with perhaps enzyme substitution therapy, and some intelligent psychotherapy, for example, may greatly benefit the

dyspeptic person, depressed and losing weight, whose uneven temper is hard on others.

Preventive geriatrics is a new concept requiring a broad approach to people as persons with potentials for degeneration and dysfunctions all along the line of medical possibilities. Diabetes, urinary infections and mechanical difficulties, nutritional fads and many relatively minor difficulties detected and corrected or controlled early may prevent later disaster and chronic disability. Surely it should not now require the dramatic impact of cancer upon a person's life to impress upon people how important it is to search for diseases in early stages and to prevent them.

"The time has now come," writes Dr. Homburger, "when it is possible to do much in a most constructive manner for a host of difficulties, and to do it better the earlier these disorders are discovered. . . . This . . . requires a new state of mind which has to be developed in the present generation of medical students, who still are inclined to consider a patient over 50 with only minor complains an 'old crock,' and a patient of 70 someone for whom nothing can be done 'anyway'."

This same antiquated medical attitude, he finds, renders it difficult for many aging persons and patients with chronic diseases to find sympathetic medical understanding and competent care. Few physicians like to deal with patients who present vague complaints and are "simply getting old," and for whom they think they can do little or nothing. This attitude results in the innumerable "nuisance patients" who go from doctor to doctor. Just because a physician did not learn in medical school how to manage effectively problems of age and chronic illness, he should not pass up the opportunity that now exists. He owes it to his patients to know the possibilities, rather than to dispense pessimism. He can at least find the specialists interested in the modern management of the paraplegic patient. He should know that — a colostomy is no calamity but can function so that a normal life is possible — a stroke may not mean the end of active life — aches and pains of old ladies may be osteoporotic and often curable rather than inevitable— gouty patients' attacks may be prevented — the arthritic patient need no longer become a hopeless prisoner of his joints without a heroic medical struggle — and even degenerative bone and joint disease may benefit from modern management or be correctable by surgery. In addition, the elderly "nuisance patient" after thorough evaluation is entitled to a program of total care which should continue, ideally, until either the patient or the physician dies. "This plan represents the ideal patient-doctor relationship, which is so much talked about but so rarely found in practice."

The family doctor is the one, of course, who should be most competent and alert in these matters. The good practitioner in geriatrics and chronic disease must be able to "forsee, forestall, discover and treat" all of these difficulties, or at least know where to get them treated. It would appear that the physician competent to practice geriatrics and treat chronically ill patients emerge as "the supraspecialist," who knows much about many specialties and who can treat and likes to treat the patient as a whole. Here truly is a tremendously urgent and fruitful field, challenging to any clinician — one of the last frontiers of medicine.

Aviation Medicine Matures
Dr. Ralph N. Greene a Pioneer

There is wide public interest today in man's conquest of the air and the space that lies beyond. Many of the achievements in this jet and rocket age have been made possible by the research discoveries of aeromedical scientists. The story of these scientists, whose mission is as boundless as the skies they are exploring, is told in a timely and significant book just off the press in March. As related in "Doctors in the Sky" by Dr. Robert J. Benford, a veteran United States Air Force flight surgeon recently named editor of the Journal of Aviation Medicine, a new and important branch of modern medicine came into being a quarter of a century ago with the organization of the Aero Medical Association. From humble beginnings in 1929 this fledgling specialty society has grown in stature and influence until today it is an international organization whose roster includes the names of leading authorities in aviation medicine from many parts of the world.

The founder of the scientific society devoted to this specialty was Dr. Louis Hopewell Bauer, eminent medical statesman and physician who served as president of the American Medical Association in 1952 and is today the acknowledged international leader of the medical profession. A leader in aviation medicine before its importance was widely acknowledged and an outstanding military flight surgeon, Dr. Bauer organized the first

school of aviation medicine in this country and probably in the world, wrote the first textbook on the subject in the United States and established the earliest physical standards for the licensing of civilian aviators by the Department of Commerce. It follows naturally that he should become "the father" of the Aero Medical Association — in fact, "Mr. Aviation Medicine" himself.

Pioneering in aviation medicine along with Dr. Bauer was a past president of the Florida Medical Association, the late Dr. Ralph N. Greene Sr. of Jacksonville and Miami. At the first meeting of the Aero Medical Association in Detroit in October 1929, Dr. Bauer was elected president and Dr. Greene was the first named of five vice presidents elected. At the invitation of Eddie Stinson, Dr. Greene's old friend, many members of the new society visited the Stinson "Detroiter" airplane factory while there and were given a flight in the new Stinson plane. In 1931 Dr. Greene succeeded Dr. Bauer, becoming the second president of the association. He presided over the annual meeting at Cleveland in 1932 and was re-elected for a second term. His photograph, a biographic sketch and a summary of his contributions to aviation medicine appear in "Doctors in the Sky."

As early as 1917 Dr. Greene reported in the Military Surgeon some of his earliest experiences in aviation medicine when he used Stinson and himself as experimental subjects. Following his presidency of the Aero Medical Association, he published many valuable articles, often on the improvement of physical examining instruments, in the Journal of Aviation Medicine and elsewhere. He is generally credited with bringing aviation medicine to the American commercial airlines by the establishment of the medical department of Eastern Air Lines in 1936. As the first medical director of this line he campaigned vigorously for the passage of a federal law limiting airline pilots to 85 hours flying time per month. In recognition of his contribution to the establishment of this policy, he was made an honorary member of the Airline Pilots Association in 1939, the only physician in the United States ever to have been so honored by this group. In 1937 he served as chairman of the Committee on Safety in Aviation and Pilot Fatigue of the Aero Medical Association, and when this body came to Florida in 1939 to hold its annual meeting at Hollywood, he happily performed the many tasks which befall an arrangements committee chairman. He maintained his affiliation with the Air Corps as a colonel in the reserve, and actively engaged in flying until shortly before his death in Coral Gables in 1941.

The silver anniversary of the Aero Medical Association in 1954 marked the culmination of 25 years of remarkable achievements in aviation medicine. Recounting them all in his narrative history of a new and fascinating professional specialty, Dr. Benford has made of "Doctors in the Sky" a particularly valuable contribution to medical history. The book is reviewed in the Books Received section of this issue of The Journal.

A.M.A. Federal Medical Services Committee Holds Busy Session

A busy two day meeting of the Committee on Federal Medical Services of the American Medical Association was held in Chicago recently. The committee, headed by Dr. Louis M. Orr of Orlando, at an all day meeting the first day reviewed the steps already taken in implementing the profession's policy on veterans' medical care and discussed new approaches. Several reports are being revised, and a number of additional studies are scheduled. As soon as recently gathered data can be tabulated, a survey of the present status of the VA's Home Town Care program will be released to the states.

It was the decision of the committee to provide the states with material on other federal medical services also, in addition to the Veterans Administration program. In the planning stage now are reports on medical care in the Panama Canal Zone and in the Indian hospitals. These data will be released soon.

On the second day, a conference was held with more than 40 physicians from 22 states, many of whom were chairmen of state committees. To them Dr. Orr said, "The purpose of this meeting is to find out from you how we can help. What data should we collect, what does your society want us to do, what do you think should be the next step in this program?" Committee members acted as co-chairmen of discussion groups for part of this meeting. The group method made it possible for all delegates to bring their suggestions before the committee and to report on methods evolved to implement the A.M.A. policy in local societies.

The consensus was that the meeting was highly successful. Several delegates suggested that the conference be repeated at an early date.

Free Medical Care Adds Up

Every day of every week in every state of the union physicians spend many an hour in clinics and hospitals and on calls for which they receive no payment and expect none. While they neither deserve nor desire undue acclaim for this service, these unpaid bills and freely-given hours nevertheless add up to lost income. Few surveys or studies have been made to determine the approximate dollar value of this free medical care and treatment. One investigator estimated a few years ago on the basis of a study he made that the average doctor devotes 12 per cent of his working hours to charity work.

Last March a state medical society reported on its inquiry into the subject of free medical care, which appears to be the most comprehensive study yet made. The New Hampshire Medical Society found in a survey conducted among general practitioners and specialists that somebody somewhere in New Hampshire gets $4 worth of free medical care and treatment every minute. The society placed the annual value of this free medical care at $2,096,640; or, expressed in another way, it amounts to $40,320 per week or $5,760 per day.

The society in a news release about its study said that "just about every practicing physician does some charity work. The scope of this depends upon the doctor's geographical location, the economic status of patients in his area, and the type of professional service rendered."

The survey indicated that on the basis of the present active membership of the New Hampshire Medical Society the average doctor in the state provides $3,425 worth of free medical care a year, slightly more than $65 weekly. That, of course, is the average. For surgeons and specialists the free care, measured in terms of dollars and cents, would be substantially greater. Free surgery, that is, surgery for which the physician-surgeon receives no payment or performs the work at a reduced rate, may amount to $1,000 or more a month, the study showed.

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to be Published
in June Issue

Political 'Care' Versus Medical Care

The laity speaks up. The Dallas Morning News said it. Under the title of "Private Security" this newspaper recently published the following figures, not failing to add pertinent comment:

"Ninety-five of every 100 workers are now covered by some kind of private — not government — benefit program. This is not the brag of private business. It is a government figure.

"Nine of ten have life insurance. Eight of ten have hospital insurance, and more than half of those have surgical policies. Six of ten are covered for sickness and accident. Five of ten have medical care. Six of ten have their own company pension coverage.

"Yes, there is growing pressure in Washington for the Federal Government to get into the medical business. It makes just as much sense as the government going into the automobile business so that those who don't have a car can have one — at taxpayers' expense. That pressure is for political 'care,' not medical care."

International Social Security Dangers Discussed

The International Social Security Association, a subject of vital interest to American physicians, was discussed at some length in the February 19 news letter of the World Medical Association. In Europe the term "social security" differs from that in the United States. There it includes compulsory government and hospital insurance.

This masterful presentation of the socialistic dangers confronting physicians in the free countries of the world is made by Dr. Louis H. Bauer, the secretary-general of the World Medical Association, who turns for his information to the official publications of the International Social Security Association. Comments Dr. George F. Lull, the secretary of the American Medical Association, "I will wager that blood pressures will jump for most American physicians when they read Dr. Bauer's letter."

The following quotation, for example, highlights the philosophy of this association, which is one of the most dangerous organizations in existence today:

"The Committee of Experts, composed of representatives of 17 nations of Europe, Asia, and America, recognizing the need for cooperation with the doctors for public health and social progress, demanded of the medical profession that it

accept the principles of social security in order to adopt its work to the needs of modern society. Collaboration is possible only if the medical profession *adopts as its own*, the principles on which social security is based. These general principles *which must* be accepted by doctors *must be laid down by legislation*."

The World Medical Association, Dr. Bauer explained in his letter, has established liaison with certain international organizations and bodies in order to present to them the views of the medical profession.

A.M.A. Annual Meeting Atlantic City, June 6-10

The 1955 Annual Meeting of the American Medical Association will be held in Atlantic City, N. J., opening on June 6 and continuing through June 10. The nearly five full days of lectures, scientific and technical exhibits, and color and motion picture presentations offer physicians an unsurpassed opportunity for keeping abreast of the latest discoveries and developments in medicine. The center of activities of the convention will be in the Atlantic City Auditorium and adjacent hotels. The Traymore Hotel will be the headquarters hotel, where the House of Delegates will convene.

A report on the Salk poliomyelitis vaccine, scheduled for presentation at a meeting of the sections on pediatrics and preventive medicine, will be one of the many outstanding scientific features of the meeting. Others include a general discussion of resuscitation of the newborn infant for the sections on anesthesiology, diseases of the chest, general practice, obstetrics, and pediatrics; exhibit-symposiums on rheumatism and diabetes; and fracture and fresh pathology exhibits.

A new feature this year will be "Queries and Minor Notes," a project having the same relation to the meeting that the printed column of that name has to The Journal of the American Medical Association. Consultants from the various sections of the Scientific Assembly will be assigned for certain hours each day at a designated place in the Scientific Exhibit to confer with physicians concerning their particular problems and answer their questions about specific cases. Almost a hundred specialists in the different branches of medicine will be on duty at various times during the week. This addition to the program promises to be especially popular.

Throughout the week, the Air Force will demonstrate its "flying infirmary" on the beach in front of the Auditorium. Some 325 scientific exhibits and 350 technical exhibits will be on display. Surgical and clinical demonstrations on the color television program will be piped directly into the auditorium from Philadelphia hospitals. On Wednesday, June 8, the auditorium will be open exclusively for physicians during the morning hours.

Florida Association of Blood Banks Meets May 14-15, 1955

The annual meeting of The Florida Association of Blood Banks will be held at The Tides Hotel, Redington Beach, on May 14 and 15. A most excellent administrative and scientific program has been arranged. Lay speakers will be Quinn Jordan, Phoenix, Ariz., Executive Director of the Southwest Blood Banks, and Dorothy C. Smith, R.N., of Jacksonville, Executive Secretary of The Florida Association of Blood Banks and Administrator of the Jacksonville Blood Bank.

Physicians on the program will include Dr. Oscar B. Hunter Jr., Washington, D. C., Vice President of the American Association of Blood Banks; Dr. Lloyd Newhouser, Miami, Medical Director of The John Elliott Blood Bank of Dade County, who recently retired from the United States Navy, where he was in charge of its blood program; and Dr. Mario Stefanini, Boston, an internationally known research worker in blood coagulation, associated with Dr. Armand Quick and then with Dr. William Dameshek for several years. Others will be Dr. John McGraw, Bryn Mawr Hospital, Bryn Mawr, Pa., a distinguished pathologist, who was a vital member of the blood program of the United States Army during World War II; Dr. William Murphy Jr., now with Dade Reagents in Miami and formerly with The National Institute of Health, where he was engaged in inspecting blood banks in all parts of the country; and Dr. James J. Griffitts, Miami, Medical Director of the Dade County Blood Bank and President-Elect of the American Association of Blood Banks, who is recognized everywhere as one of the outstanding blood bank physicians.

The program schedule follows:

MAY 14, 1955

MORNING SESSION:

Moderator, Mrs. Mary Rand, Orlando

8:45 a.m. Registration
9:30 Invocation
9:35 Welcome, Clyde O. Anderson, M.D., President, Pinellas County Medical Society
9:40 Blood and Insurance Programs of Southwest Blood Banks, Quinn Jordan, Phoenix, Ariz.
10:20 Florida Blood Banks Clearing House — Brief Report of 15 Months Operation, Dorothy C. Smith, R.N., Jacksonville
Questions and Answers
11:00 Intermission
11:10 The Role of the American Association of Blood Banks in the Future of Blood Bankings, Oscar B. Hunter Jr., M.D., Washington, D.C., Vice President, American Association of Blood Banks
12:15 Luncheon

AFTERNOON SESSION

Moderator, David R. Murphey Jr., M.D., Tampa

2:00 p.m. Practical Consideration of Nuclear Energy Blasts, Lloyd Newhouser, M.D., Miami
2:45 Bleeding Problems Affecting Blood Banks, Mario Stefanini, M.D., Boston
3:30 Intermission
3:45 Transfusion Reactions, John J. McGraw, M.D., Bryn Mawr, Pa.
4:30 Avoidable Errors in Blood Transfusion, William Murphy Jr., M.D., Miami

MAY 15, 1955

MORNING SESSION

10:00 a.m. Blood Immunology Workshop, James J. Griffitts, M.D., Miami
10:00 Business Meeting

PRESIDENT McEWAN'S ADDRESS SCHEDULED FOR PUBLICATION IN JUNE ISSUE

Graduate Medical Education

Short Course
June 20-24, 1955

The Twenty-Third Annual Graduate Short Course for doctors of medicine, presented by the Department of Medicine of the Graduate School of the University of Florida, the Florida Medical Association, and the Florida State Board of Health, will be given this year on June 20-24 at the George Washington Hotel in Jacksonville. Except for last year and one previous year, all of the Short Courses have been held at approximately this time.

A special effort was made this year to have some of the previous lecturers return to present this course. Most favorably received in the past, these outstanding medical teachers undoubtedly will be enthusiastically received this year. The lectures on Medicine will be presented by Dr. Eugene A. Stead Jr., Professor of Medicine, Duke University School of Medicine, and Physician-in-Chief, Duke University Hospital, Durham, N. C. His lucid presentations dealing with the most recent advances in medicine will be of interest to internists as well as to general practitioners. Pediatrics will be given by Dr. Wilburt C. Davison, Dean and Professor of Pediatrics, Duke University School of Medicine, Durham, N. C. Dr. Davison is well known to practically every physician in Florida. His address before the Florida Medical Association at its annual meeting in 1954 was both scholarly and informative. His lectures will be most helpful to the pediatrician and the general practitioner.

Dr. Herman D. Kerman, Associate Professor of Radiology and Director of the Radioisotope Laboratory, University of Louisville School of Medicine, Louisville, Ky., will present information assisting all physicians in understanding the roentgenologist's interpretation of x-ray films and also will lecture on the latest research related to his particular field, in which he is highly qualified. Dr. William F. Rienhoff Jr., Associate Professor of Surgery and Instructor of Surgical Anatomy, The Johns Hopkins University School of Medicine, Baltimore, is also well known to the medical profession of Florida. His unique presentations always contain a fund of information valuable to the surgeon as well as the general practitioner. Dr. E. C. Hamblen, Professor of

Endocrinology and Associate Professor of Obstetrics and Gynecology, Duke University School of Medicine, Durham, N. C., will deliver the lectures on Gynecology. This is the third time in 23 years of presenting the Short Course that emphasis has been placed on endocrinology as it relates to gynecology. No one is better qualified to handle this particular subject than Dr. Hamblen, who has graciously made many sacrifices to return this year.

For the first time in presenting the program of the Short Course, summaries of all the lectures will be shown on the printed program to be mailed to each doctor in Florida by the State Board of Health. For instance, Dr. Stead summaries his lectures on Medicine as follows: "Treatment of Hypertension: The question of when to treat patients in the course of hypertensive vascular disease will be reviewed. The advantages and disadvantages of dietary, drug and surgical therapies will be discussed;" "Treatment of Chronic and Undiagnosed Illnesses: The problem of the relationship between doctor and patients in chronic illness and during periods of diagnostic uncertainty will be covered;" "Examinnation of the Autonomic Nervous System: The methods of history taking and physical examination in diseases of the autonomic nervous system will be covered. Clinical syndromes from such disorders will be presented;" "Fundus in General Practice: The things to be learned about systemic disease from examination of the eyegrounds will be stressed;" and "Minor Clinical Pearls: A running account of some of the highlights in diagnosis and therapy which have come to the attention of the author from the patients he has seen in the last few months."

Another innovation this year is the medical and surgical panels to be held on Tuesday and Friday afternoons. Many requests have been made for these panels, and the Committee believes they will be well attended and well received. The members of the panel are shown on the program.

A special feature this year is the dinner to be given on Wednesday evening. Invited guests are the President of the University of Florida, the Provost of the J. Hillis Miller Health Center and the Dean of the College of Medicine of the University of Florida, officers of the Florida Medical Association, and officers of the State Board of Health. Members of the Graduate Faculty of the Department of Medicine of the University of Florida will be urged to attend this dinner. In addition, any member of the Florida Medical Association, whether registered for the Short Course or not, desiring to attend the dinner will be welcome if he makes a dinner reservation in advance. The guest speaker as well as other speakers will be announced later.

The schedule for the Short Course appears on the opposite page.

Seminar on Psychiatry
June 16-18, 1955

Following the practice of the past several years, there will be a special Seminar held just prior to the week of the Short Course. This year the subject selected by the Committee on Medical Postgraduate Course is Psychiatry. The program planned and the lectures are designed not for the specialists in psychiatry but for all physicians practicing medicine in any field where human relationship is an important part of their professional work. Special stress both in the lectures and in the evening public meetings is being placed on alcoholism and child guidance.

The Faculty will consist of Dr. Hans Lowenbach, Professor of Psychiatry, Duke University School of Medicine, Durham, N. C., who gave the lectures on Psychiatry at the Short Course last year and was well received; Dr. Leo H. Bartemeier, Medical Director of The Seton Institute, Baltimore; and Dr. Virginia L. Clower, Staff Member of the Douglas A. Thom Child Guidance Clinic, Cambridge, Mass.

The course will begin at 10 a.m. on Thursday, June 16, at the George Washington Hotel in Jacksonville and will continue until noon on Saturday, June 18. Registration will begin at 9 a.m. on June 16, but all doctors who plan to attend this Seminar are urged to make advance registration. The fee has been materially reduced this year. The first evening program open to the public will be devoted to Child Guidance and will be handled by Dr. Lowenbach and Dr. Clower. The second evening program will be on Alcoholism and will be under the direction of Dr. Bartemeier and Dr. Lowenbach. Mr. Ernest A. Shepherd, Administrator of the State of Florida Alcoholic Rehabilitation Program, will be present at the Friday evening meeting and will bring the medical profession and lay audience up to date on the progress of the sanatorium at Avon Park.

SCHEDULE FOR SHORT COURSE

HOUR	Monday June 20	Tuesday June 21	Wednesday June 22	Thursday June 23	Friday June 24
8:00	**Registration**				
9:00	**Medicine** "Treatment of Hypertension" Dr. Stead	**Medicine** "Examination of the Autonomic Nervous System" Dr. Stead	**Roentgenology** "Supervoltage Radio therapy with a Cobalt 60 Unit" Dr. Kerman	**Surgery** "The Surgical Treatment of Diseases of the Lung" Dr. Rienhoff	**Gynecology** "Virilization Syndromes of the Pubescent and Adult Female" Dr. Hamblen
10:00	**Pediatrics** "The Evolution of Infant Feeding and the Advantages and Disadvantages of Soured Milk Mixtures" Dr. Davison	**Pediatrics** "Childhood Cancer" Dr. Davison	**Pediatrics** "Accidents and Poisoning" Dr. Davison	**Gynecology** "Amenorrhea Including Apubescence and Hypopubescence" Dr. Hamblen	**Surgery** "Surgical Treatment of Diseases of the Liver" Dr. Rienhoff
11:00	**Recess**	**Recess**	**Recess**	**Recess**	**Recess**
11:30	**Roentgenology** "Roentgenologic and Clinical Observations in the Diagnosis of Carcinoma of the Pancreas" Dr. Kerman	**Roentgenology** "Radioiodine in Thyroid Disease" Dr. Kerman	**Medicine** "Fundus in General Practice" Dr. Stead	**Surgery** "Surgical Treatment of Diseases of the Thyroid" Dr. Rienhoff	**Gynecology** "Endocrinological Factors in Female and Male Sterility" Dr. Hamblen
12:30	**Lunch**	**Lunch**	**Lunch**	**Lunch**	**Lunch**
2:00	**Pediatrics** "Child Health Care by General Practitioners and Pediatricians" Dr. Davison	**Pediatrics** "Diarrhea and Dysentery" Dr. Davison	**Pediatrics** "Nephritis and Nephrosis in Children" Dr. Davison	**Gynecology** "Functional Excesses of Uterine Bleeding" Dr. Hamblen	**Surgery** "Surgical Treatment of Diseases of the Gallbladder" Dr. Rienhoff
3:00	**Recess**	**Recess**	**Recess**	**Recess**	**Recess**
3:15	**Roentgenology** "Roentgenologic Features of Some Common Pediatric Problems" Dr. Kerman	**Medical Panel** Subject to be announced Moderator: Dr. Karl B. Hanson	**Medicine** "Minor Clinical Pearls" Dr. Stead	**Surgery** "Recent Development of Carcinoma of the Stomach" Dr. Rienhoff	**Surgical Panel** Subject to be announced Moderator: Dr. Edward Jelks
4:15	**Recess**		**Recess**	**Recess**	
4:30	**Medicine** "Treatment of Chronic and Undiagnosed Illnesses" Dr. Stead	Panel Members: Dr. Stead Dr. Davison Dr. Kerman Dr. George T. Harrell Jr.	**Roentgenology** "Therapeutic Uses of Radioisotopes" Dr. Kerman	**Gynecology** "Sexual Precocity in Female and Male" Dr. Hamblen	Panel Members: Dr. Reinhoff Dr. Hamblen Dr. C. Frank Chunn Dr. John D. Milton
5:30			Cocktail Hour and Dinner		

OTHERS ARE SAYING

One More Complaint Satisfied?

The barrage of criticism which has all but inundated the medical profession for the last two decades has included such heavy salvos as: "Not enough doctors" and the more sinister allegation "The doctors keep down the number of new doctors who are graduating, so as to limit competition."

Obviously, the first criticism stems from those who have found it hard to get a physician for night calls or house calls. Potentiating this personal disgruntlement is the everyday observation that there is, and has been, a maldistribution of physicians. For instance, a heavily populated area may have one physician for a few hundred, whereas a less congested area may have only one physician for several thousand citizens. The latter condition, moreover, usually is in sparsely settled areas which means that communication and transportation problems make matters worse. Of course, the second quote is merely a smooth sophistry, a lie. The practicing physicians in the United States have little or nothing to say about who gets into medical schools, how many graduate each year, or what they study. Perhaps these young graduates (and the whole medical profession) would be infinitely better off if *practicing physicians* did have something to say about these matters!

But now comes the real dope on this "doctor ratio" business. During the last year the ratio of physicians to population has reached a record, one physician for every 730 persons in the United States. This ratio will be lowered in the next few years because the record of 6,861 physicians in the 1953-54 crop will be exceeded in the next and succeeding years.

There will be 7,449 freshmen in the total of 28,227 medical students this year, the greatest number of medical students in history. Ten new four-year medical schools will be opened within the next few years, and despite all the detractors, no one can honestly charge that the medical profession is holding back in this matter.

It is apparent that this phase of the problem is rapidly being solved, and we can only hope the second phase, maldistribution, will follow in due course.

—Missouri Medicine, November 1954

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"Medically approved" is the magic phrase in advertising today. Buy this relaxing chair: your doctor recommends it. Our brand of toilet paper is certified by leading dermatologists to be kind to your skin. So with cigaret holders which filter out the poison, air conditioners which control your climate, and background music which soothes your nerves. A triangular pillow is approved by neurologists as aiding relaxation and a mattress has been accoladed by orthopedists as leading to better posture. There is even a new seat cushion which interposes its foamy self between your ischial tuberosities and the seat of your chair. This too bears the unofficial approval of an anonymous and — just possibly — nonexistent doctor. So fashionable is this today, that only a reckless retailer would open a store without a physician-in-waiting to give his sanction to the shoes, cigarettes, scallions, and light bulbs which he might sell.

In a way it is a double tribute to the physician. A tribute first because it suggests that the layman does respect the opinions of his doctor. And a tribute in another way too: it would be so easy for the practitioner to wander slightly off the reservation and accept a fee for endorsing something. So easy, that it is heart-warming to note how few M.D.s really do it.

—The Journal of the Medical Society of New Jersey, November 1954

Striving for Our Ideal

In an anxious and broken world, marked by marvelous and awesome scientific progress, the physician should be the first to realize that science is no answer for the multiple longings and aspirations of the human spirit. Genuine interest in the patient as a person is more important now than in the days of our fathers. It is imperative that we perfect our tools in human relationships to the same point that we have perfected the tools of science, in order that we may enter into the minds of our patients with sympathy and understanding, without judgment or criticism, and in a spirit of true helpfulness.

To the modern physician, much has been given, and of him much is required. Great things are expected of him and little allowance is made for his shortcomings. As always in medicine, our ideal exceeds our performance. Perhaps this is fortunate, for only in striving for the ideal can we best serve those who seek our service, and also protect our heritage and deliver it to the coming generations of physicians in a continuity of past, present, and future.—*Paul F. Whitaker, M.D., in North Carolina Medical Journal.*

—*The Journal of the Indiana State Medical Association, February 1955*

Medical Officers Returned

Dr. Charles N. Stevens, who entered military service on July 4, 1952, was released from active duty on July 4, 1954 with the rank of first lieutenant, U. S. Army. His address is 510 W. Tennessee St., Ft. Myers.

Dr. Wayne B. Martin, who entered military service on Aug. 16, 1953, was released from active duty on Feb. 5, 1955 with the rank of first lieutenant, USNR. His address is 1502 Milan Ave., Coral Gables.

Dr. Peritz Scheinberg, who entered military service on Aug. 20, 1953, was released from active duty on Feb. 19, 1955 with the rank of lieutenant commander, U. S. Navy. His address is 1000 N. W. 17th St., Miami.

BIRTHS AND DEATHS

Dr. and Mrs. James G. Robertson of Miami announce the birth of a daughter, Kim Evelyn, on Feb. 18, 1955.

Dr. and Mrs. James H. Mendel Jr. of South Miami announce the birth of a son, Peter Allan, on Feb. 23, 1955.

Dr. and Mrs. George W. Robertson III of Miami announce the birth of a son, Thomas Harriman, on March 14, 1955.

Deaths — Members

Ward, Albert L., Port St. Joe..... March 27, 1955

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Abel, Bernard, Miami
Anderson, Oliver D., Hialeah
Arnold, Carl J. Jr., Cocoa
Atkinson, Sam C., Jacksonville
Binder, Charles I., Miami Beach
Carleton, Charles C., Apopka
Cason, M. Louise, Miami
Cook, James R., Orlando
Cusani, Benedict A., Miami
Daniel, Ben E., Titusville
Duckworth, Alda G., Orlando
Everts, William H., West Palm Beach
Gallagher, James F. Jr., Miami
Glassman, Jacob A., Miami
Haas, Stuart L., Miami
Hadden, Shirley L., Live Oak
Jensen, Louis C. Jr., Cocoa
Manrodt, Spencer C., Melbourne
Marr, Norval M. Jr., St. Petersburg
Massari, Frank A., Tampa
Parker, John H. Jr., Perry
Raborn, Robert E., Delray Beach
Reinartz, Paul V., Jacksonville
Rose, Eugene C. (Col.), St. Petersburg
Shaner, Harold J., Orlando
Sims, Murry, Coral Gables
Snider, Ross A., Jacksonville
Theodorou, George, Fort Pierce
Troutman, Erwin W., Miami
Wagner, Glen, Melbourne
Weible, David M., Clearwater
Williams, John E., Miami

STATE NEWS ITEMS

The fourth annual Symposium for General Practitioners on Tuberculosis and other Chronic Pulmonary Disease will be held in Saranac Lake, New York from July 11 to 15, 1955. It is approved for 26 hours of formal credit for members of the American Academy of General Practice. Sessions will be held in the various sanatoria, hospitals and laboratories in the Saranac Lake area. The faculty will consist of physicians, surgeons and scientists from Saranac Lake as well as guest lecturers. The registration fee for the Symposium is $40. Further information and copies of the program can be obtained by writing Dr. Richard P. Bellaire, General Chairman, Symposium for General Practitioners, P.O. Box 2, Saranac Lake, N. Y.

Dr. Donald H. Gahagen of Fort Lauderdale presided at the District Meeting of the American Cancer Society held in West Palm Beach on February 25.

Dr. M. Crego Smith of Clearwater entered medical service with the U. S. Air Force on Feb. 20, 1955.

Drs. Jack W. Fleming, Raymond B. Squires, John R. Emlet and John M. Packard of Pensacola and William J. Overman of Warrington spoke at the Second Biennial Cardiovascular Disease Institute at Sacred Heart Nurses Home on March 2. Dr. Fleming's subject was the prevention of heart disease and its complications; Dr. Squires spoke on recent advances in the treatment of heart disease, and Dr. Emlet's subject was "Surgical Treatment of Heart Disease." Drs. Packard and Overman served as moderators during question and answer periods.

Dr. G. Dekle Taylor of Jacksonville spoke at a meeting of the Laryngectomee Club on February 23.

Drs. William K. Barton and Leonard Freed of St. Petersburg were among the speakers at a cancer program, "Investment Day," held by the American Cancer Society Dressing Unit of Pasadena Community Church in February.

Dr. Walter F. Davey of Stuart has been named Martin County Health Officer to succeed Dr. Julian D. Parker.

Dr. Edward L. Cole Jr. of St. Petersburg spoke on February 21 to members of the Pinellas Association for Retarded Children on "Retarded Children and Their Problems."

Dr. William W. Schildecker of Daytona Beach spoke on cancer before the Seminole County Chapter of the American Cancer Society on February 21.

Dr. C. Frank Chunn of Tampa has been named Fleet Surgeon, and Dr. Thomas M. Edwards of Tampa, Fleet Captain, of the Tampa Yacht and Country Club.

Dr. James A. Craig of Naples has been elected president of the newly-formed Naples Clinical Society. Dr. Ethel H. Trygstad was chosen secretary.

Dr. Julius C. Davis of Quincy was elected vice president of the Southeastern Surgical Congress at the meeting in Atlanta in March.

Dr. Louis L. Amato of Fort Lauderdale spoke on "The Care of the Aged" before the Licensed Practical Nurses Association on March 3.

Dr. C. MacKenzie Brown of Tampa spoke on the prevention of anesthetic accidents before the Licensed Practical Nurses' Association of that city on March 11.

Dr. J. Brooks Brown of Jacksonville is working with the business and professional division of the 1955 Cancer Crusade in Duval County.

Dr. Charles F. Biggane Jr. of North Miami spoke before a meeting of the Miami Shores Business and Professional Women's Club on March 3.

Dr. H. Phillip Hampton of Tampa spoke on "Weight Control Is Important" at a public nutrition program presented on March 1.

In a Today's Health gift subscription contest designated "Operation Christmas," one of four awards presented to local woman's auxiliary groups throughout the country was won by a Florida society. The Woman's Auxiliary to the Dade County Medical Association received the award in the group having 100 members or over. The contest was sponsored by the Woman's Auxiliary to the American Medical Association. Mrs. Richard F. Stover of Miami is national Today's Health chairman.

Dr. John M. Packard of Pensacola spoke on the heart at a meeting of the Pensacola Civitan Club in February.

Dr. Nathan L. Marcus of Tampa was moderator for a group discussion which followed the previewing by local physicians of a tape recording of the sound of the human heartbeat.

Dr. Herman Selinsky of Miami spoke at the third anniversary celebration of the Bal Harbour chapter of Alcoholics Anonymous on February 28.

Dr. George P. Beach of Daytona Beach spoke on cerebral palsy before the Volusia County Parents Association for Physically Handicapped Children on February 28.

The Florida Trudeau Society, the medical branch of the Florida Tuberculosis and Health Association, will hold its annual meeting at the McAllister Hotel in Miami on May 13 and 14, 1955. The first session opens at 2 p.m. on Friday, May 13, with Dr. Lawrence C. Manni, President, of Tallahassee, presiding. Dr. Harold W. Johnston, Vice President, of Orlando, will preside at the second session, opening at 8:30 on Saturday morning, with adjournment of the meeting scheduled for noon. The secretary of the society is Dr. Simon D. Doff of Jacksonville.

The opening address on Friday afternoon, entitled "Adenomas of the Bronchus," will be presented by Captain C. F. Storey, MC, USN, Chief of Surgery, U. S. Naval Hospital, Portsmouth, Va. A panel discussion on "Pathology and Pathogenesis of Pulmonary Tuberculosis, Its Relation to Treatment and Prognosis" will open the program Saturday morning. The moderator will be Dr. David Smith, Duke University School of Medicine, Durham, N. C., and the panelists will be Dr. Julius L. Wilson, Director of Medical Education, American Trudeau Society, New York; Captain Storey; Dr. Benjamin L. Brock, Medical Director, Central Florida Tuberculosis Hospital, Orlando; and Dr. William L. Potts, Medical Director, Southeast Florida Tuberculosis Hospital, Lantana. In addition, 11 Florida essayists have places on the program, including Dr. George T. Harrell Jr., Dean of the College of Medicine, University of Florida, Gainesville.

June 6 through 10, the dates set for the 1955 Annual Meeting of the American Medical Association, are only a month away. This annual gathering will be held at Atlantic City, N. J., a site which now, as on past occasions, provides a most satisfactory meeting place. Florida physicians who plan to attend will find it to their advantage to make their hotel reservations early and receive an Advance Registration Card by mail. All registrations are to be cleared by the Local Subcommittee on Hotels, and those who register well in advance of the meeting will be assured of suitable accommodations.

Dr. Joseph W. Eversole of Jacksonville gave a paper on "The Practical Application of Histochemistry to Surgery" at the meeting of the Southeastern Surgical Congress held in Atlanta in February.

Dr. Gordon H. Ira of Jacksonville is taking a five week postgraduate medical clinical tour of Europe. He will attend medical meetings and clinics in France, Italy, Germany, Denmark, Sweden and England.

Dr. O. E. Harrell of Jacksonville has been named vice president of the City Planning Advisory Board.

Dr. Clarence M. Sharp spoke on the work of health departments in the field of tuberculosis at the Florida Conference of Tuberculosis Workers held in Gainesville in February.

Dr. Sharp also spoke on tuberculosis at a recent meeting of the Virginia Tuberculosis Association held in Richmond.

Dr. Gary E. Turner of Jacksonville took part in a panel discussion on "Why Some Children Become Delinquents" at the February meeting of the Springfield Park School P.-T.A.

Dr. Sidney Storch of Jacksonville has returned to his practice after a week at the Department of Internal Medicine, Division of Graduate Training of Tulane University of Louisiana School of Medicine.

Dr. Turner Z. Cason of Jacksonville spoke on "Diseases of the Heart" at a March meeting of the Zonta Club.

Dr. Cason also spoke before the March meeting of the Duval Medical Center Auxiliary. His subject was the work of the outpatient department.

At the second biennial Cardiovascular Disease Institute for Nurses held in March in Jacksonville, Dr. Roy M. Baker spoke on "Prevention of Heart Disease and its Complications;" Dr. James E. Cousar III spoke on "Surgical Treatment of Heart Disease and its Complications;" Dr. James talk on "Diagnosis and Medical Treatment of Cardiovascular Disease;" and Dr. A. Sherrod Morrow talked on "The Dietary Control of Cardiovascular Disease." Drs. Turner Z. Cason and Karl B. Hanson were moderators of panel discussions.

In Viewing the VA Medical Program . . .

we are not talking about...

1. VA Form 10-P-10
2. Ability of veterans to pay
3. Efficiency of VA Administration
4. Extent of abuse



The medical profession is not concerned with alleged maladministration of present legislation by the Veterans Administration or with abuses by veteran-applicants of the hospital and medical care privileges. The nation's physicians do not feel that they have the responsibility to police the veterans medical care program, although they have cooperated wholeheartedly in assuring that veterans hospitalized under the present VA laws receive the highest quality of medical care.

Dr. Thad Moseley of Jacksonville gave the first of a two part course sponsored by the Civilian Defense Council. The subject was rational conduct in the face of an emergency.

Dr. Simon D. Doff of Jacksonville spoke on tuberculosis at an Alabama Tuberculosis Conference held in Birmingham recently.

Dr. George M. Stubbs of Jacksonville has been elected first vice president of the Jacksonville Emory Alumni Association.

Dr. Philip L. Smoak of Tampa was elected commander of the Tampa Power Squadron at a meeting held March 3 at the Davis Islands Yacht Club.

Dr. Lucien Y. Dyrenforth of Jacksonville attended his twenty-fifth medical class reunion at Emory University recently.

Dr. William Y. Sayad of West Palm Beach, Dr. W. Jerome Knauer Sr. of Jacksonville, and Drs. Sherman B. Forbes and Hugh E. Parsons of Tampa attended the Fifteenth Clinical Meeting of the Wilmer Residents Association, The Wilmer Ophthalmological Institute, The Johns Hopkins Hospital and University, held in Baltimore on March 30 and April 1 and 2.

WANTED — FOR SALE

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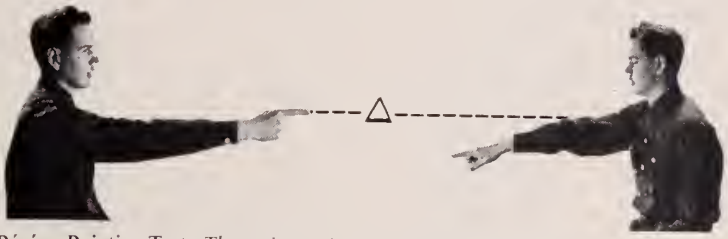
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Notes on the Diagnosis and Management of "Dizziness"

I. Vertigo

The term "dizziness" (vertigo) should be restricted to the sensation of whirling or a sense of motion.[1] This sensation is usually of organic origin and is the tangible symptom of a specific pathology.

Moderate vertigo, with a sense of motion and a whirling sensation, may be produced by infection, trauma or allergy of the external or middle ear. Examination of the ear will usually disclose the abnormality.

Severe vertigo, which will not permit the patient to stand and causes nausea and vomiting, indicates an irritation or destruction of the labyrinth. The specific condition may be labyrinthine hydrops, an acute toxic infection, hemorrhage or venospasm of the labyrinth or a fracture of the labyrinth. Multiple sclerosis and pathology of the brain stem should be considered also.

It is important to learn if the patient's sensation is continuous or paroxysmal.[2] Paroxysmal vertigo suggests specific conditions: Ménière's syndrome, cardiac disease and epilepsy. Continuous vertigo without a pattern may be due to severe anemia, posterior fossa tumor or eye muscle imbalance.

Dramamine® has been found invaluable in many of these conditions. In mild or moderate vertigo it often allows the patient to remain ambulatory. A most satisfactory treatment regimen for severe "dizziness" is bedrest, mild sedation and the regular administration of Dramamine.

Dramamine is also a standard for the management of motion sickness, is useful for relief of nausea and vomiting of radiation sickness, eye surgery and fenestration procedures.

Dramamine (brand of dimenhydrinate) is supplied in tablets (50 mg.) and liquid (12.5 mg. in each 4 cc.). G. D. Searle & Co., Research in the Service of Medicine.

1. Swartout, R., III, and Gunther, K.: "Dizziness:" Vertigo and Syncope, GP *8*:35 (Nov.) 1953.

2. DeWeese, D. D.: Symposium: Medical Management of Dizziness: The Importance of Accurate Diagnosis, Tr. Am. Acad. Ophth. *58*:694 (Sept.-Oct.) 1954.

SEARLE

COMPONENT SOCIETY NOTES

Dade

At the regular meeting of the Dade County Medical Association on April 14, Dr. Walter W. Sackett Jr. gave a paper on "Responsibility of the Personal Physician as the Cancer Detection Clinic of Today;" and Dr. Richard C. Clay spoke on "How the American Cancer Society Helps the Dade County Physician in the Care of Cancer Patients."

Duval

At the regular monthly meeting of the Duval County Medical Society on March 1, Dr. Philip M. Stimson of New York, professor of clinical pediatrics at Cornell University Medical College, spoke on "Recent Advances in Poliomyelitis."

At the meeting on March 29, Drs. Phillip W. Horn, Simon D. Doff, Augustus E. Anderson Jr. and Clarence M. Sharp took part in a symposium on "Recent Advances in Medical Chest Diseases."

Escambia

Dr. George T. Harrell Jr. of Gainesville, dean of the School of Medicine of the University of Florida, was guest speaker at the regular monthly meeting of the Escambia County Medical Society on March 8. His subject was "Sodium and Potassium."

Hillsborough

At the regular meeting of the Hillsborough County Medical Association on April 12, Dr. James F. Lyons of Coral Gables spoke on "A New Method for Treating Peripheral Vascular Diseases."

Lake

The regular monthly meeting of the Lake County Medical Society was held at Howey-in-the Hills on March 2. Dr. Henry L. Harrell of Ocala spoke on "Cancer of the Breast."

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Monroe

Dr. Waltman Walters, professor of surgery at the University of Minnesota Medical School and a member of the staff of the Mayo Clinic, spoke on March 3 at a joint meeting of the Monroe County Medical Society and the staff of the Naval Hospital. Dr. Walters' subject was "Peptic Ulcers."

Palm Beach

At the regular monthly meeting of the Palm Beach County Medical Society on February 28, Dr. James Barrett Brown, professor of clinical surgery, Washington University School of Medicine, St. Louis, was guest speaker. His subject was "Plastic Surgery."

Index for Volume XLI
Scheduled for Publication
June Issue

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OBITUARIES

Dorothy Jane Speers

Dr. Dorothy Jane Speers died at her home in Titusville on Jan. 4. 1955. She was 32 years of age.

The daughter of Mr. and Mrs. Frank E. Nodine of Clearwater, Dr. Speers was born at Titusville, Pa., on Jan. 10, 1922. She received her academic training at Florida State University and was awarded the degree of Doctor of Medicine by Columbia University College of Physicians and Surgeons in New York in 1949. She was a member of Phi Beta Kappa.

Upon graduation, she entered the general practice of medicine in Titusville, where she became a leader in professional circles and civic affairs. She was the wife of Dr. James F. Speers, Director of the Brevard County Health Department. Recently, she established a clinic in Titusville and limited her practice to obstetrics. In addition, she headed a drive to secure pledges for the building of a hospital there. She was also active in the First Presbyterian Church.

Dr. Speers was a member of the Brevard County Medical Society, the Florida Medical Association and the American Medical Association. She also held membership in the American Academy of General Practice.

In addition to her husband and her parents, Dr. Speers is survived by a son, David Allen Speers; one sister, Mrs. Julian Mawhinney, of Clearwater; and three brothers, William E. Nodine, of Clearwater, Dr. John Nodine, of Philadelphia, and Robert H. Nodine, of New Haven, Conn.

Orin Ross Yost

Dr. Orin Ross Yost of Ormond Beach died at his home of a heart ailment on Jan. 23. 1955. He was 49 years of age.

Born in Kimball, W. Va., in 1906, Dr. Yost received the degree of Doctor of Medicine from the Medical College of Virginia in 1930. He served an internship in neurology at St. Elizabeth's Hospital in Washington, D. C., and a medical internship at Pilgrim Hospital in Long Island. Later he taught psychiatry at Columbia University and was a staff member of the Vanderbilt Clinic and Institute of Living at Hartford,

Conn. During World War II he served from 1941 to 1945 as assistant chief of neuropsychiatry at Fort Jackson, S. C., and at Lawson General Hospital. After his military discharge he was superintendent of the Weston State Hospital in West Virginia until 1946. About 1946 he organized the Edgewood Sanitarium at Aiken, S. C., and later moved it to Orangeburg, S. C. Since that time he had served as its medical director. While active in South Carolina, he was voted an honorary life member in the State Junior Chamber of Commerce in recognition of his distinguished service.

This noted psychiatrist was the author of "What You Should Know About Mental Health" and "The Bane of Drug Addiction," both published in 1954. He was also a widely known lecturer on mental health.

Dr. Yost first made his home in Florida in 1949, locating at Ormond Beach. He suffered a heart attack there in 1952 and afterward lived in semiretirement until he gave up his practice last October. He was a consultant in psychiatry at Halifax District Hospital in Daytona Beach. A member of the Ormond Beach Rotary Club, he was also a member of the BPOE Lodge 1141 of Daytona Beach. He attended Tourist Church.

Licensed to practice medicine in Florida since January 1954, Dr. Yost was a member of the Volusia County Medical Society and the Florida Medical Association. He also held membership in the American Medical Association. A fellow of the American Psychiatric Association, he was a past president of the Southeastern Society of Neurology and Psychiatry. In addition, he served as an affiliate of the National Committee on Cooperation With Lay Groups for the promotion of National Mental Health Week.

Dr. Yost is survived by his widow, Mrs. Edith S. Yost; two sons, Lyle Yost and Orin Yost Jr., and one daughter, Miss Patricia Yost, all of Ormond Beach; two brothers, Carl Yost, of New York City, and Fred Yost, of Alexandria, Va.; and two grandchildren.

William Miller Stinson

Dr. William Miller Stinson of Jacksonville died in an Asheville, N. C., hospital on Oct. 24, 1954. He was 81 years of age.

A native of Mississippi, Dr. Stinson was born in Canton in 1873. He received his medical training in Tennessee and was awarded the degree of Doctor of Medicine by the Memphis Hospital

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Bumbalo, T. S., Gustina, F. J., and Oleksiak, R. E.: J. Pediat. 44:386, 1954.

White, R. H. R., and Standen, O. D.: Brit. M. J. 2:755, 1953.

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Brown, H. W.: J. Pediat. 45:419, 1954.

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Medical College in 1900. He then came to Jacksonville and in 1902 was licensed to practice medicine in Florida.

During World War I Dr. Stinson served in the United States Army Medical Corps. He continued in military service for many years and upon retirement returned to Jacksonville to live. He was active in civic affairs and was a member of the Timuquana Country Club and the Presbyterian Church. At one time he was Florida state golf champion.

Dr. Stinson was a member of the Duval County Medical Society and had held honorary membership for five years. He became a member of the Florida Medical Association in 1904. Also, he for many years was a member of the American Medical Association.

His first wife, Mrs. May A. Stinson, died in 1940. He later married Mrs. Flora N. Doe, who survives him. A sister, Mrs. Margaret Stinson Yeargain, of Jacksonville, also survives.

Lowell Sinn Selling

Dr. Lowell Sinn Selling of Orlando and Winter Park died at the Orange Memorial Hospital in Orlando on Jan. 18, 1955. He suffered a heart attack two days after breaking a hip in a fall. He was 52 years of age.

A native of Michigan, Dr. Selling was born in Detroit on March 17, 1902. He attended the University of Michigan, Columbia University, and New York University and was awarded seven degrees, including M.D., Ph.D., and Dr.P.H. In 1928 he received his medical degree from Bellevue Hospital Medical College and then served a residency there, specializing in psychiatry.

From 1934 until 1944, Dr. Selling was Director of the Recorders' Court Clinic in Detroit. In 1947 he came to Florida to direct the mental health program for the Florida State Board of Health and from 1948 to 1950 served as acting director of the Bureau of Maternal and Child Health. During that period he also served as psychiatric consultant for Florida State University and acting director of the Orange County Health Unit guidance clinics. In 1948 he entered private practice in Orlando.

This distinguished psychiatrist was the author of seven widely read books, including "Men Against Madness" and "Synopsis of Neuropsychiatry." In addition, he had more than 100 articles published in medical journals.

Dr. Selling was a member of the Orange County Medical Society, the Florida Medical Association and the American Medical Association. He was a fellow of the American College of Physicians. A member of the American Board of Psychiatry and Neurology, he also held membership on the American Board of Examiners in Professional Psychology. He was chairman-elect of the Psychiatric Section of the Academy of Forensic Sciences and was to take office in February. He had held every office in the Medical Correctional Association, an association which endeavors to improve prison conditions.

Surviving are the widow, the former Mary Paradis; a son, Fred Selling, of Detroit; and a son, Bernard B. Selling, and a daughter, Mary Lee Selling, both of Winter Park.



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BOOKS RECEIVED

Doctors in the Sky, The Story of the Aero Medical Association. By Robert J. Benford, M.D. Pp. 327. Price, $8.75. Springfield, Ill., Charles C. Thomas, Publisher, 1955.

This narrative history of the Aero Medical Association tells how and why the society was founded, and traces its growth from the initial small group of 35 physicians in 1929 to the prominent international organization it has become today, including among its members the leading authorities in aviation medicine from many parts of the world. It is a fitting tribute to Dr. Louis H. Bauer, the founder and first president. Here is a factual, well conceived account in excellent popular and historical perspective which covers the development of the Journal of Aviation Medicine, the establishment of the Lyster, Longacre and Tuttle Awards, the rise of airline and civilian aviation medicine, and the attainment of certification. It describes the 25 annual meetings of the Aero Medical Association, the notable scientific presentations, and the achievements of the organization whereby it has broadened the horizons of aeronautical knowledge, contributed immeasurably to safety in flying, and cemented a strong alliance between medicine and aeronautics.

This airborne saga of aviation medicine is the story that members of the association and flight surgeons have lived in the air, on the flight line, and in the laboratory. The important role of the late Dr. Ralph N. Greene Sr., of Jacksonville and Miami, the organization's second president, is recounted in some detail. There are chapters on CAA and airline medicine, the twenty-fifth annual meeting, the struggle for specialty recognition, awards and traditions, and the Wives' Wing together with lists of officers and fellows, biographic sketches of the presidents and a wealth of additional information not previously assembled in one volume. The author is a veteran United States Air Force flight surgeon, who has recently been named editor of the Journal of Aviation Medicine.

The Medical Care of the Aged and Chronically Ill. By Freddy Homburger, M.D. Pp. 253. Price, $5.75. Boston, Little, Brown and Company, 1955.

Off the press in mid-March, this book is intended for practitioners, medical students, nurses and intelligent laymen who face the many problems created by chronic illness and by the varying needs of aged and debilitated patients.

Today the number of those who become old and finally ill and debilitated increases steadily, as medical progress saves lives of countless patients who in days past would have fallen victim to infectious diseases and other disorders which physicians have learned to control. There are millions of patients with long-lasting, poorly understood diseases and with crippling disabilities, whose care requires special skills and concern not only with the disease but with the patient's personal problems.

This book provides practical guidance for the handling of these special situations, which are given little attention in the curriculums of medical schools and which present irksome problems for those who have to meet them and cope with them in day-to-day practice. It will save untold hours of library work for physicians who wish to bring themselves up to date on recent advances in the management of chronic illness. Also, in many instances

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it will provide physicians, nurses and families with the key to successful handling of patients, which may mean the difference between a hopeless and useless existence and rehabilitation to a useful and far more tolerable life.

The author, born and educated in Switzerland, has been Research Professor of Medicine at Tufts College Medical School in Boston since 1948 and is well known as the organizer and director of the Cancer Research and Cancer Control Unit there. He has published many scientific articles and is the senior editor of the monumental treatise The Physiopathology of Cancer. A teacher of renown, he has taught at Yale University School of Medicine, Harvard Medical School, Cornell University Medical College, and the Memorial Center for Cancer and Allied Diseases in New York.

The Adolescent Exceptional Child, a Realistic Approach to Treatment and Training. Proceedings of the 1954 Spring Conference of the Child Research Clinic of The Woods Schools. Pp. 80.

This pamphlet is the report of a conference held in New Orleans last year by The Woods Schools, a nonprofit residential school for exceptional children in Langhorne, Pa., in cooperation with the Tulane University of Louisiana School of Medicine, the Louisiana Association for Retarded Children, and others. The subjects discussed are diagnosis, treatment and training of the retarded child, with emphasis on vocational training. The object of the conference was to exchange information and discuss ways to help the retarded child depend on his own resources and skills in adult life. The talks of the speakers are given in full. A section of the pamphlet is devoted to a panel discussion on occupational placement of the retarded child from the parent, teacher and professional points of view. Copies of the pamphlet are available without charge from the Child Research Clinic of The Woods Schools, Langhorne, Pa.

Reproductive System. Volume 2 of the Ciba Collection of Medical Illustrations. Prepared by Frank H. Netter, M.D. Edited by Ernst Oppenheimer, M.D. Pp. 302. Price, $13.00. Summit, N. J., Ciba Pharmaceutical Products, Inc.

Volume 2 of the Ciba Collection of Medical Illustrations is a remarkable compilation of paintings on the normal and pathologic anatomy of both the male and the female reproductive systems. The reception accorded Volume 1 of this series, issued last year and entitled "Nervous System," has made reprinting urgent and bespeaks like interest for this second volume in Ciba's project of portraying in desirable details the major anatomy and pathology of all the systems comprising the human organism, devoting a separate volume to each system. The medical profession in the United States has become well acquainted with the superior excellence of the illustrative talent of Dr. Netter, the senior author of both of these volumes.

Of the 233 plates presenting a virtually complete pictorial story of the structure and disorders of the human reproductive system, 89 appear in print for the first time in this book. The other 144 plates were published previously in Ciba Clinical Symposia or in special folders or brochures over a period of 11 years, all of which have been carefully checked for corrections according to the most modern concepts. Interestingly, 75 per cent of the pages handsomely portray pathology of both primary and secondary male and female sex organs; that is, disorders in their form and function. This visual and verbal description of pathologic conditions has considerable clinical value and also aids effectively the acquisition of the physiologic knowledge so badly needed. The books of this series are offered as a nonprofit service to the medical profession and are sold at the cost of publication and distribution.

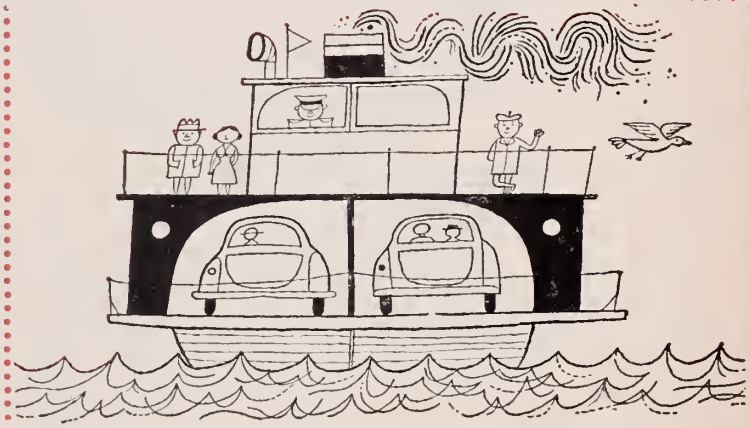
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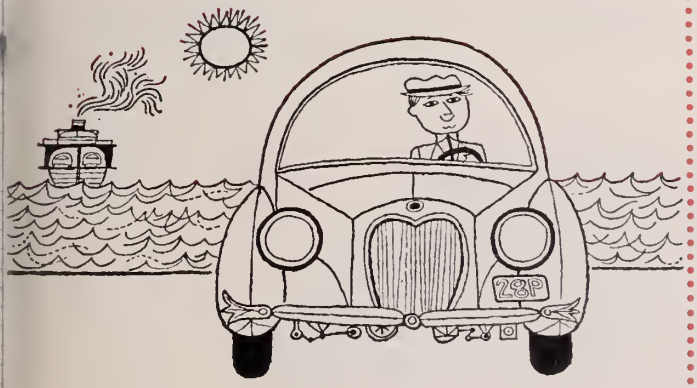
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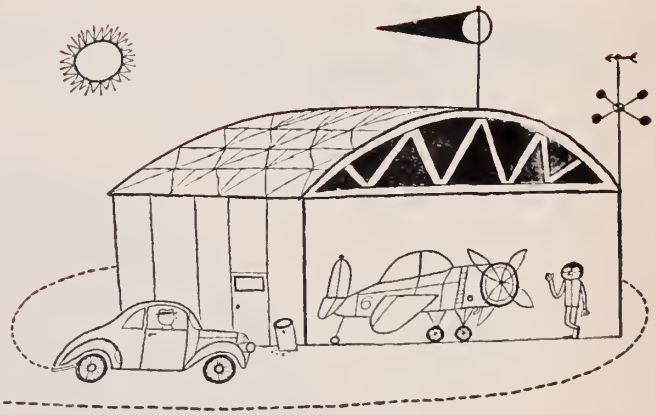






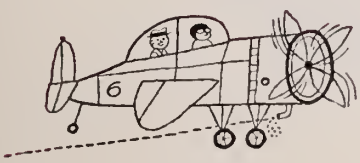






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(Continued from page 976)

Ciba Foundation Symposium on Hypertension, Humoral and Neurogenic Factors. Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and Margaret P. Cameron, M.A., A.B.L.S. Pp. 294. Illus. 73. Price, $6.75. Boston, Little, Brown and Company, 1954.

The problem of hypertension and its effects on the cardiovascular system is approached in this symposium from the functional point of view, or the point of view of applied physiology. A future symposium will deal with the second aspect of the problem, the epidemiologic point of view. The papers and discussions in this book are not only informative and stimulating, but also give the reader a sense of participation in an informal and friendly occasion.

This is one of the books of The Ciba Foundation for the Promotion of International Cooperation in Medical and Chemical Research. The foundation, located in London, is an international center, established as an educational and scientific charity under the laws of England. It owes its inception and support to its founder, Ciba Ltd. of Switzerland, but is administered independently and exclusively by its distinguished British trustees. This unique organization provides accommodations for scientific workers who visit London from abroad, organizes and holds international symposia, and renders many other valuable services in its endeavor to promote international cooperation in scientific research. Leading research workers from different countries and in different disciplines are invited to attend the symposia or colloquia. Since the size of the groups is necessarily small, excluding many active and interested workers, the proceedings of these conferences are published and made available throughout the world. This book is an excellent example of this service.

Ciba Foundation Symposium on the Kidney. Edited by A. A. G. Lewis, B.Sc., M.D., M.R.C.P., and G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch. Pp. 333. Illus. 125. Price, $6.75. Boston, Little, Brown and Company, 1954.

This book contains the reports, plus some of the ensuing discussions, presented at a meeting in London in July 1953 by a select group of scientists who have conducted much of the scientific research on the kidney. The ground covered at this symposium included structural and functional relationships in the kidney, the regulation of acid base balance, tubular functions other than the regulation of acid base balance, general problems of electrolyte excretion, and the renal share in the volume control of body fluid. Part 4, which describes some of the problem of electrolyte excretion, is particularly noteworthy since this subject is occupying the attention of many research workers at the present time.

The members who participated in the symposium were chosen for their eminence in those aspects of renal anatomy, physiology, pathology and medicine that it was desired to integrate for study. They included experts from England, Belgium, Denmark, France, Holland, Sweden, Switzerland and the United States. The 22 papers presented were published in book form by the Ciba Foundation of London, described in the foregoing review of a similar symposium on Hypertension.

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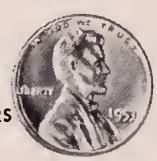
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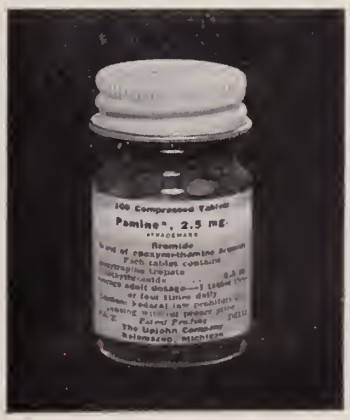
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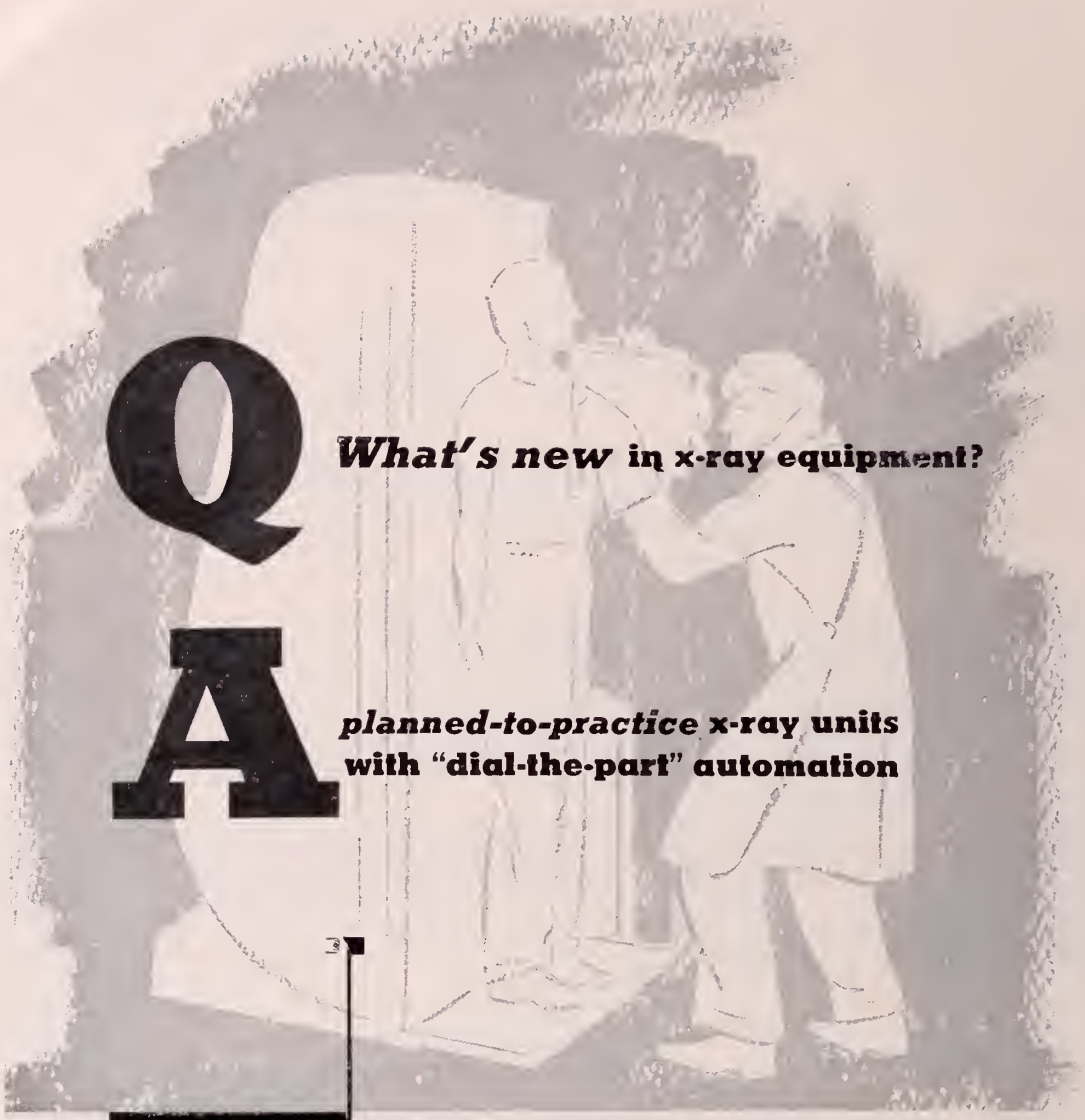
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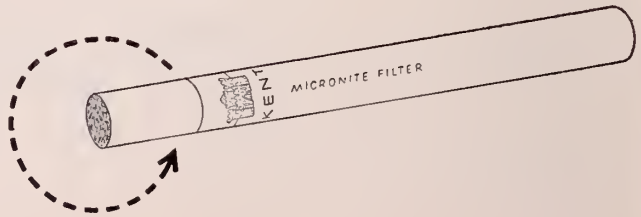
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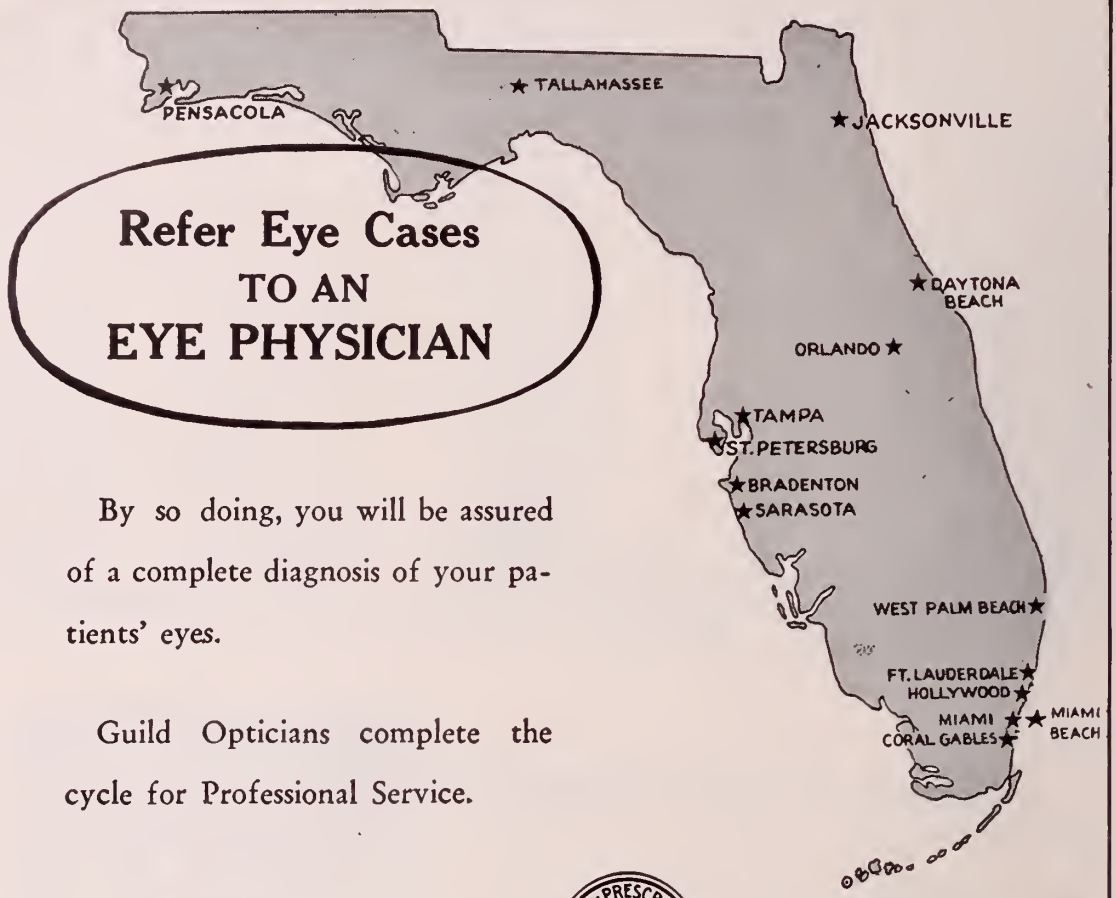
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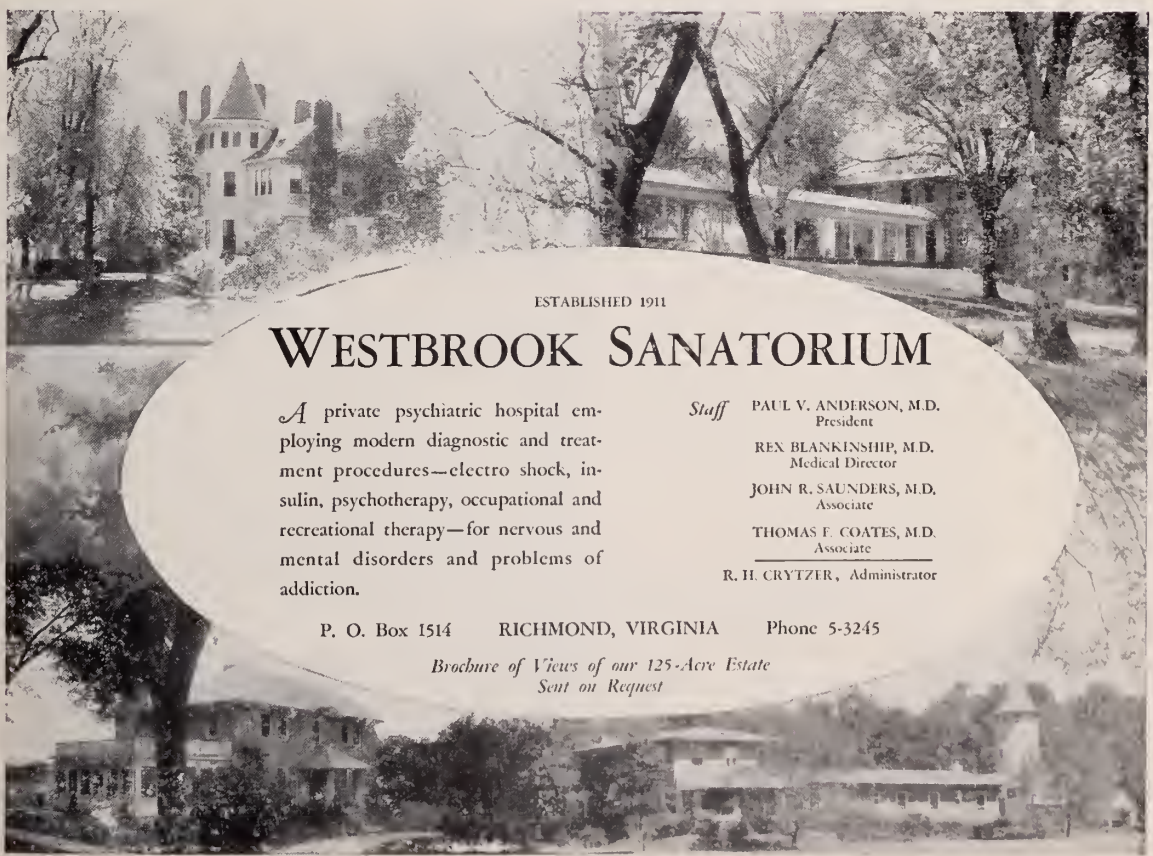
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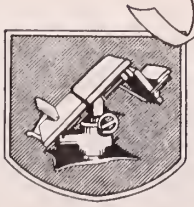
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
orida Medical Association	John D. Milton, Miami	Samuel M. Day, Jacksonville	Miami Beach, May 13-16, '56
orida Medical Districts	Ralph W. Jack, Miami	Council Chairman	
A-Northwest	William P. Hixon, Pensacola	Walter J. Baker, Foley	Pensacola
B-Northeast	Henry J. Babers Jr., Gainesville	Charles L. Park Sr., Sanford	Gainesville
C-Southwest	C. Frank Chunn, Tampa	James R. Boulware Jr., Lakeland	Lakeland
D-Southeast	James R. Sory, West Palm Beach	Ralph S. Sappenfield, Miami	Fort Lauderdale
lorida Specialty Societies			
cademy of General Practice	Frank T. Linz, Tampa	James B. Hodge Jr., Tampa	
llergy Society	W. Ambrose McGee, W. P. Bch.	Norris M. Beasley, Ft. Lauderdale	
nesthesiologists, Soc. of	Wayland T. Coppedge Jr., Jax.	William H. Houston, Jacksonville	
hest Phys., Am. Coll., Fla. Chap.	Hawley W. Seiler, Tampa	William L. Potts, Lantana	
erm. and Syph., Assn. of			
ealth Officers' Society	Clarence L. Brumback, W. P. Bch.	Lorenzo L. Parks, Jacksonville	
ndustrial and Railway Surgeons	Frank L. Fort, Jacksonville	John H. Mitchell, Jacksonville	
eurology & Psychiatry	Edward H. Williams, Miami	J. Robert Campbell, Tampa	
b. and Gynec. Society	J. Champneys Taylor, Jacksonville	Reuben B. Chrisman Jr., Miami	
phthal. & Otol., Soc. of	Charles W. Boyd, Jacksonville	Kenneth S. Whitmer, Miami	
rthopedic Society	Edward W. Cullipher, Miami	Robert P. Keiser, Coral Gables	
athologists, Society of	Millard B. White, Sarasota	Wray D. Storey, Tampa	
ediatric Society	Wesley S. Nock, Coral Gables	Joel V. McCall Jr., Daytona Beach	
roctologic Society			
adiological Society	Hugh G. Reaves, Sarasota	Donald H. Gahagen, Ft. Lauderdale	
urgeons, Am. Coll., Fla. Chapter	Joseph S. Stewart, Miami	C. Frank Chunn, Tampa	
rological Society	David W. Goddard, Daytona Bch.	W. Dotson Wells, Fort Lauderdale	
lorida—			
Basic Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, May 14, '55
Blood Banks, Association	John T. Stage, Jacksonville	John B. Ross, Jacksonville	St. Petersburg, 1955
Blue Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	
Blue Shield of Florida, Inc.	David R. Murphey Jr., Tampa	Jack O. W. Rash, Miami	
Cancer Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	
Clinical Diabetes Assn.	Sidney Davidson, Lake Worth	Edward R. Smith, Jacksonville	Daytona Beach, Oct. 20-21, '55
Dental Society, State	Robt. Thoburn, D.D.S., Daytona Bch	J. E. Edwards, D.D.S., Coral Gables	
Heart Association	Alvin E. Murphy, Palm Beach	Daniel R. Usdin, Jacksonville	
Hospital Association	Mr. Pat N. Groner, Pensacola	Mr. Steve F. McCrimmon, C. Gbls.	St. Petersburg, Nov. 16-18, '55
Medical Examining Board	Frank D. Gray, Orlando	Homer L. Pearson Jr., Miami	
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, June 20-24, '55
Nurse Anesthetists, Fla. Assn.	Miss Dorothy Jackson, C. Gables	Mrs. Lalla F. Bryan, Miami	St. Petersburg, Dec. 6-8, '55
Nurses Association, State	Martha Wolfe, R.N., Coral Gables	Agnes Anderson, R.N., Orlando	Daytona Beach, Nov. 28-30 '55
Pharmaceutical Association, State	Mr. J. L. McDonald, St. Augustine	Mr. R. Q. Richards, Ft. Myers	Clearwater, May 23-25, '55
Public Health Association	Mr. J. A. Mulrennan, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Daytona Beach, Oct. 20-22, '55
Trudeau Society	Lawrence C. Manni, Tallahassee	Simon D. Doff, Jacksonville	Miami, May 12-14, '55
Tuberculosis & Health Assn.	Judge Ernest E. Mason, Pensacola	Mrs. W. J. Norton, Sarasota	Miami, May 12-14, '55
Woman's Auxiliary	Mrs. Richard F. Stover, Miami	Mrs. S. J. Wilson, Ft. Lauderdale	
merican Medical Association	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	Atlantic City, June 6-10, '55
A.M.A. Clinical Session	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	Boston, Nov. 29-Dec. 2, '55
outhern Medical Association	Robt. L. Sanders, Memphis, Tenn.	Mr. V. O. Foster, Birmingham	Houston, Nov. 14-17, '55
labama Medical Association	J. M. Donald, Birmingham	Douglas L. Cannon, Montgomery	
eorgia, Medical Assn. of	Peter B. Wright, Augusta	David Henry Poer, Atlanta	Augusta, May 1-4, '55
E. Hospital Conference	Mr. John W. Gill, Vicksburg, Miss.	Mr. Pat Groner, Pensacola	
outheastern Allergy Assn.	Ben Miller, Columbia, S. C.	Kath. B. MacInnis, Columbia, S. C.	Charlotte, N. C., Oct. '56
outheastern. Am. Urological Assn.	Sidney Smith, Raleigh, N. C.	Robert F. Sharp, New Orleans	Hollywood, Mar. 25-29, '56
outheastern Surgical Congress	Donald S. Daniel, Richmond	B. T. Beasley, Atlanta	Richmond, Mar. 12-15, '56
ulf Coast Clinical Society	Walter C. Payne Sr., Pensacola	Barkley Beidleman, Pensacola	Pensacola, Oct. 27-28, 1955

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SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Total Members
Alachua	Edwin H. Andrews, Gainesville	Henry S. Blank, Gainesville	2nd Tues.	56
***Bradford, Gilchrist, Union**				
Bay	William F. Humphreys Jr., Panama City	Roderick C. Webb, Panama City	1st Tues.	26
Brevard	Lee Rogers Jr., Cocoa	Charles E. Russell, Cocoa	2nd Tues.	33
Broward	Ernest E. Serrano, Hollywood	Alfred E. Cronkite, Fort Lauderdale	4th Tues.	120
Columbia	Robert B. Harkness, Lake City	Thomas H. Bates, Lake City	1st Mon.	11
***Baker, Hamilton**				
Dade	L. Washington Dowlen, Miami	Robert F. Dickey, Miami	1st Tues	715
De-Soto-Hardee-Highlands-Glades	Gordon H. McSwain, Arcadia	Harold S. Agnew, Arcadia	1st Tues.	28
Duval	Raymond H. King, Jacksonville	Eugene M. Frame, Jacksonville	1st Tues.	294
***Clay**				
Escambia	George W. Morse, Pensacola	Paul F. Baranco, Pensacola	2nd Tues.	107
***Santa Rosa**				
Franklin-Gulf	Warren T. Weathington, Apalachicola	Joseph P. Hendrix, Port St. Joe	Last Wed.	6
Hillsborough	Frank S. Adamo, Tampa	Julien C. Pate Jr., Tampa	1st Tues.	185
Indian River	Kip G. Kelso, Vero Beach	Vernon L. Fromang, Vero Beach	2nd Tues.	11
Jackson-Calhoun	Henry I. Langston, Marianna	Francis M. Watson, Marianna	Quarterly	17
Lake	Louis R. Bowen, Eustis	J. Basil Hall, Tavares	1st Wed.	30
***Sumter**				
Lee-Charlotte-Collier-Hendry	Baker Whisnant, Fort Myers	James L. Bradley, Fort Myers	3rd Mon.	39
Leon-Gadsden-Liberty-Wakulla-Jefferson	William L. Hunter, Monticello	Odis G. Kendrick Jr., Tallahassee	Quarterly	67
Madison	A. Franklin Harrison, Madison	Wallace E. Winter, Madison		6
Manatee	Marjorie L. Warner, Bradenton	Harvey C. Pauley Jr., Bradenton	2nd Tues.	30
Marion	William H. Turnley, Ocala	Bertrand F. Drake, Dunnellon	3rd Tues.	30
***Levy**				
Monroe	Ralph Herz, Key West	William R. Ploss, Key West	1st Thurs.	13
Nassau	David G. Humphreys, Fernandina Beach	John W. McClane, Fernandina Beach	Last Fri.	11
Orange	Don C. Robertson, Orlando	Walter A. Derrick, Orlando	3rd Wed.	192
***Osceola**				
Palm Beach	Edwin W. Brown, West Palm Beach	James R. Anderson, West Palm Beach	4th Mon.	141
Pasco-Hernando-Citrus	Harry G. Brownlee, Zephyrhills	W. Wardlaw Jones, Dade City	2nd Thurs.	17
Pinellas	Clyde O. Anderson, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	229
Polk	Samuel J. Clark, Lakeland	Marion W. Hester, Lakeland	2nd Wed.	99
Putnam	Grover C. Collins, Palatka	Alfred P. Peretti, Palatka	2nd Tues.	10
St. Johns	George C. Hopkins, St. Augustine	Reuben J. Plant Jr., St. Augustine	3rd Tues.	21
St. Lucie-Okeechobee-Martin	Henry E. Branca, Fort Pierce	Adrian M. Sample, Fort Pierce	3rd Thurs.	22
Sarasota	Melvin M. Simmons, Sarasota	Andrew J. Jesacher, Sarasota	2nd Tues.	60
Seminole	John M. Morgan, Sanford	Terry Bird, Sanford	2nd Tues.	20
Suwannee	William P. Blackmon, Mayo	Hiram B. Curry, Jasper	1st Sat.	10
Taylor	John H. Parker Jr., Perry	Ralph J. Greene, Perry	Last Fri.	5
***Dixie, Lafayette**				
Volusia	Robert L. Miller, Daytona Beach	Achille A. Monaco, Daytona Beach	2nd Tues.	85
***Flagler**				
Walton-Okaloosa	Richard H. Lee, Crestview	Frederic E. Caldwell, Fort Walton Beach	3rd Tues	20
Washington-Holmes	L. H. Paul, Bonifay	Bayllye W. Dalton, Chipley		5
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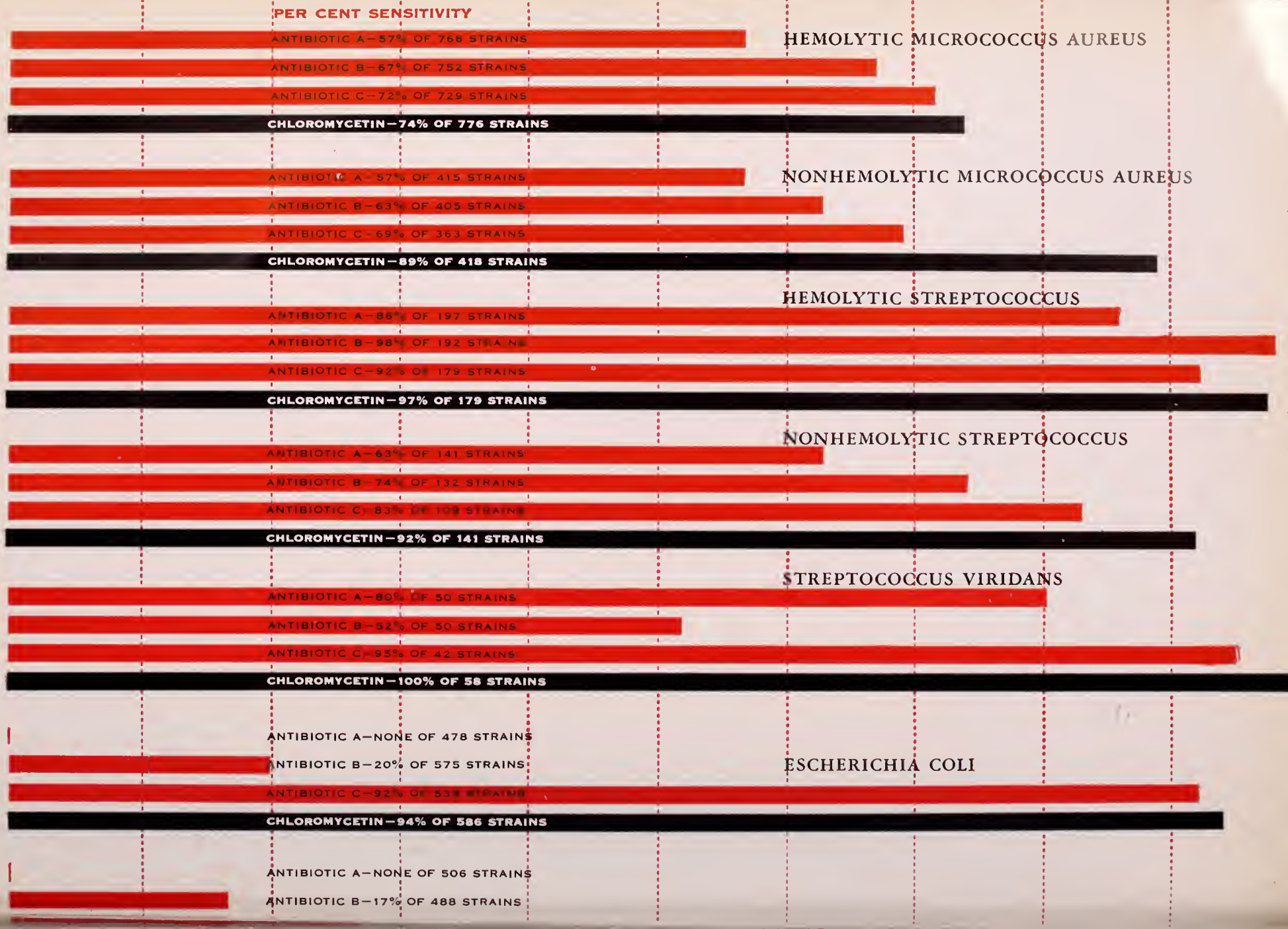
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Duncan T. McEwan

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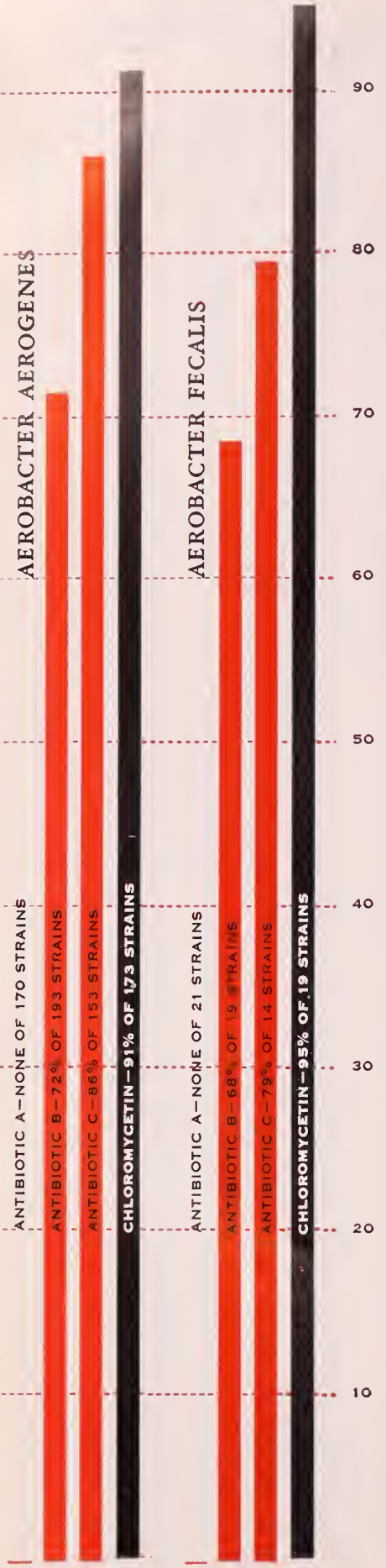
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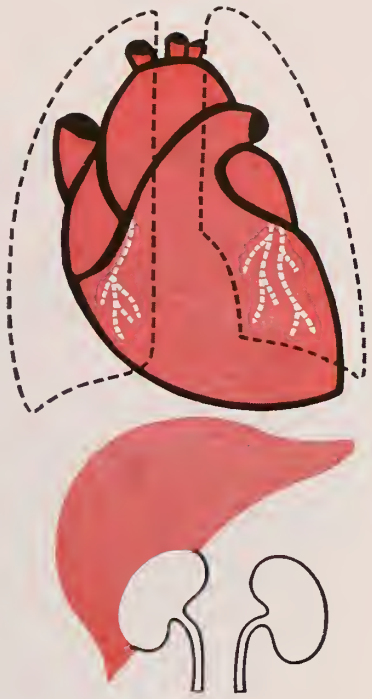
Adapted from Altemeier, W. A.; Culbertson, W. R.; Sherman, R.; Cole, W.; Elstun, W. & Fultz, C. T.: *J.A.M.A.* 157:305 (Jan. 22) 1955.

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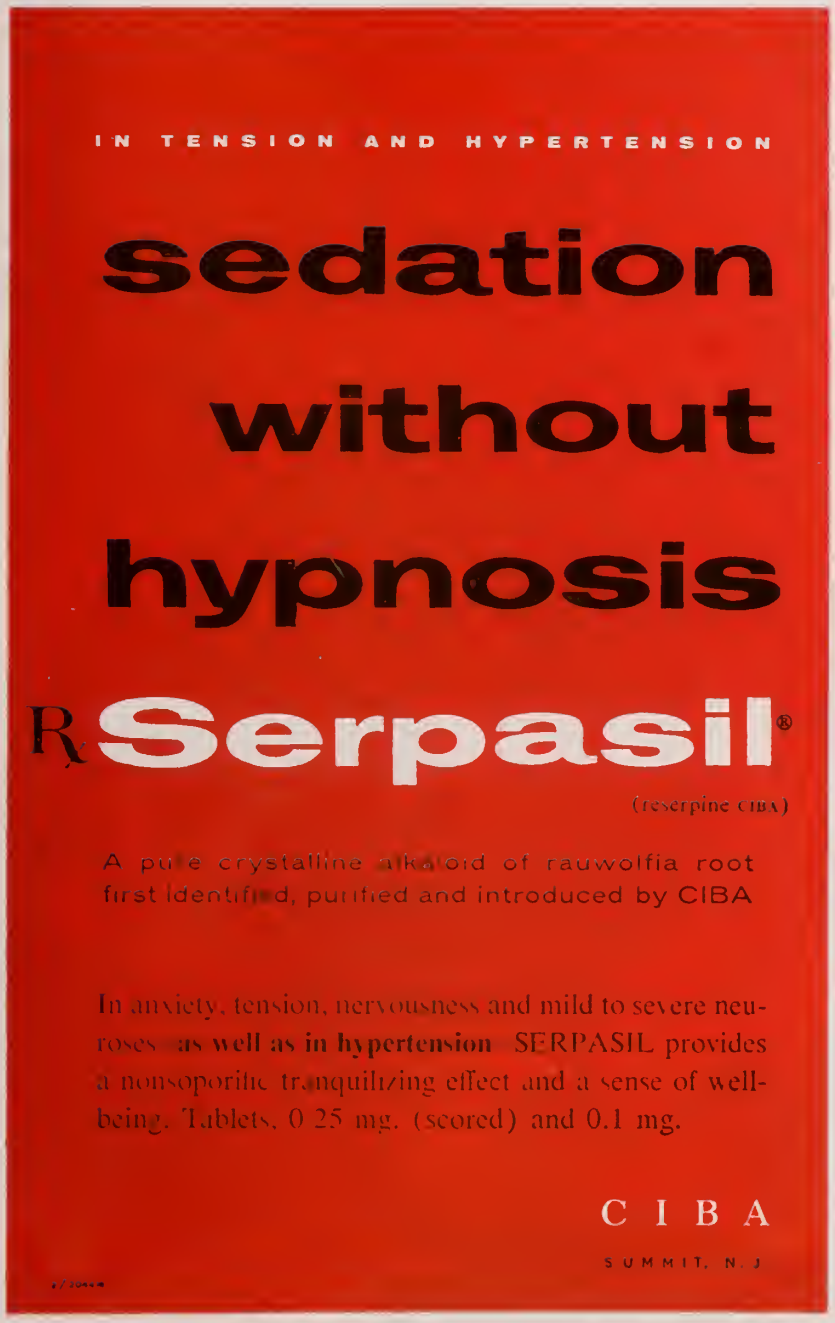
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(1) Poyne, R. W.; Shetlar, M. R.; Forr, C. H.; Hellbaum, A. A., and Ishmael, W. K.: J. Lab. & Clin. Med. *45*:331, 1955. (2) Bunim, J. J.; Willioms, R. R., and Black, R. L.: J. Chron. Dis. *1*:168, 1955. (3) Holbrook, W. P.: M. Clin. North America *39*:405, 1955.

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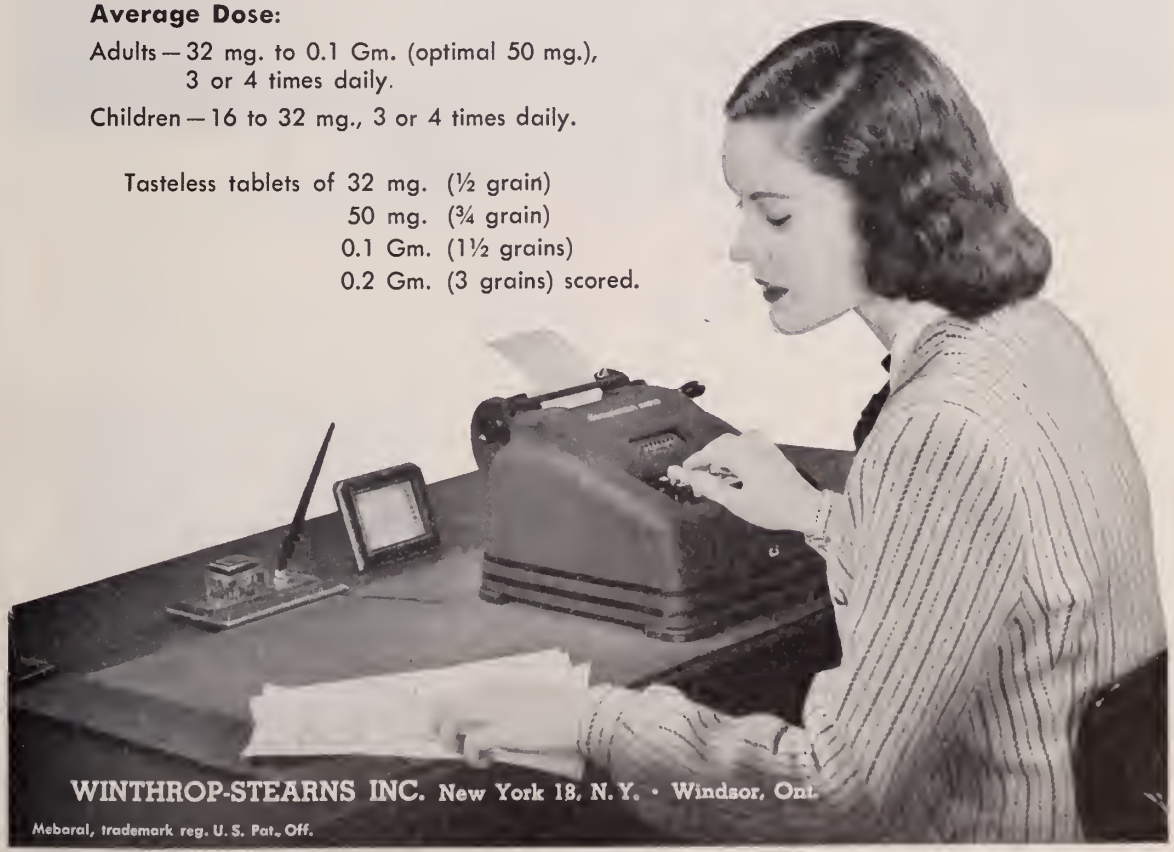
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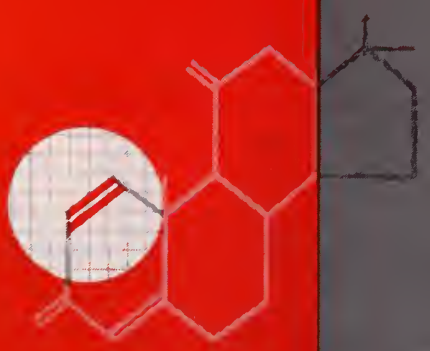
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XLI | Jacksonville, Florida, June, 1955 | No. 12

President's Address

DUNCAN T. MCEWAN, M.D.
ORLANDO

My term in office as your President is drawing to a close. I reach this point with mixed emotions: appreciation to you who gave me the privilege of serving in this capacity; satisfaction with things accomplished; regrets that some plans and dreams have not been realized; and gratitude to the members for their loyal cooperation.

To me, the most impressive thing of the past year has been the interest and hard work of the membership toward betterment of our Association. It is only now, as President, that I fully realize the sacrifice of time, money, thought and energy that our Association committees give for the benefit of their fellow practitioners and for the welfare of their community, state and nation.

Time does not permit me, today, to mention and recognize all the splendid work that the chairmen and their committees have done during the past year. I should like, however, to discuss some of the accomplishments, a few of the problems, and several plans and policies formulated.

Public Relations

As you remember, you, the House of Delegates, at our meeting in April 1954 established a new system for the direction of our public relations problem. A closer liaison between the Board of Governors and the Public Relations Bureau of the Executive Office was established, and this new method of directing and supervising these activities has been remarkably successful. It was most fortunate that Dr. Edward Jelks accepted the direction of the public relations work. He and his committee have traveled many miles and have spent many hours stimulating enthusiasm for better public relations by contacting the component county medical societies and assisting with their programs. In this way they have created better cooperation and coordination with allied auxiliaries and like groups. There is abundant evidence of aggressive, well planned, and effective public relations programs in many of our county societies, and this interest must be instilled in our entire membership. We tend to overlook the ever present threat of socialized medicine, but there is a greater need for sound public relations programs today than ever before. The efforts of the past are just beginning to pay dividends, and this important work must be carried on.

Legislation and Public Policy

There is a close relationship between the Public Relations Bureau and the Committee on Legislation and Public Policy. It assists the committee at all times. There is an allocation of personnel between the legislative and public relations activities. This year the prelegislative conference was held earlier than in the past. This seems to be an effective procedure as it enables the committee to place the legislative program in the hands of the county societies in time for them to discuss it with their representatives and senator. This is essential as the success of the program depends on aid and cooperation at the county level. Mr. W. Harold Parham, Supervisor of the Bureau of Public Relations, mans an information office during the session of the state legislature. County societies are kept advised of the progress of the bills and actions and attitudes of their legislators. This committee functions on a national as well as a state level. Pertinent bills of the Congress are studied and analyzed, and the position of the American Medical Association is noted carefully. Also, steps are taken to contact Florida congressmen when requested by the A.M.A. office. Dr. H.

Read before the Florida Medical Association, Eighty-First Annual Meeting, St. Petersburg, April 5, 1955.

Phillip Hampton is chairman of this very active committee and he and his members spend an unbelievable amount of their time in this work.

Medical Economics

One of the most active and hard-working of all of our committees is that of Medical Economics, which is headed by Dr. Robert E. Zellner. Its activities have covered several fields, but perhaps the greatest task has been working toward a solution of the malpractice problem. Our Secretary, Dr. Samuel M. Day, started this important work, which has been carried on so ably by this committee. The Board of Governors has approved its recommendation that a broker be authorized to contract for a new insurance policy on professional liability insurance. This project is still in a developmental stage and will be pursued further by the committee and the Board of Governors. I wish to call to your attention the articles on malpractice insurance written by Dr. Zellner which have been appearing in The Journal of the Florida Medical Association, as well as to the recommendations in his committee report, which is published in the Handbook for Members of the House of Delegates. He has emphasized the fact that insurance by itself is not the answer to our problem but that it is an individual responsibility of our members and of our county medical societies. I heartily advise that all county medical societies study his recommendations so that a unified program can be built up in our Association. In this way, not only is there the possibility that insurance premiums will be reduced, but our relationships with the lay public will be improved.

Grievance Committee

The question of malpractice is definitely associated with our Grievance Committee. This committee was first proposed and established by Dr. Walter C. Payne Sr., the chairman. He has been largely responsible for the development of this important adjunct to our Association, which has been of immense value in our public relations program. I should like to stress the importance of its increase in value if the public, on a county level, were informed of the existence of such a committee so that complaints could be brought to it rather than aired publicly.

The Council

Your Council, headed by Dr. Francis H. Langley, has been very industrious during the past year. The district meetings arranged by the Councilors were most successful from the standpoint of attendance and interest, and your officers enjoyed the excellent entertainment and friendly comradeship provided by the host societies. These meetings enable us to get viewpoints on our problems from the various sections of the state. An innovation this year was the panel type of program. It received many favorable comments and created popular approval of the scientific program. The Council, besides arranging the district meetings, acts as an investigating and censoring body. These unpleasant but invaluable duties have been carried out by the Council in a very impartial and understanding manner.

Woman's Auxiliary

The close cooperation between the Association and the Woman's Auxiliary this year has been most satisfactory. This is one of the most important facets of our state organization and has been headed by the very capable Ann Stover. With her committees we have striven to correlate the functions and purposes of our organizations. The Woman's Auxiliary has assisted us greatly in the public relations and legislative programs. With the cooperation of the Association they published and distributed to various women's groups an excellent pamphlet on voluntary health insurance. A very satisfactory meeting was held by the ladies of the Auxiliary at Redington Beach, St. Petersburg, which your President, with Dr. Charles R. Sias representing the Advisory Committee to Woman's Auxiliary, and Mr. Ernest R. Gibson, Managing Director of the Association, attended. I wish to commend the Auxiliary on its major projects of the year, such as its support to the Brewster School of Nursing in Jacksonville, its exhibit on nurse recruitment and "Today's Health" at the Florida State Fair in Tampa, its support of Future Nurses' Clubs, and its aid to the American Medical Education Foundation.

Blue Shield

In 1946, to combat the threat of government medicine, Blue Shield was organized by such leaders of our Association as Drs. Leigh F. Robinson, Frederick J. Waas, Walter C. Jones, and Edward Jelks. It was recognition of the fact that people in the low income bracket could not afford medical care that led us to take action to help them obtain such aid by voluntary health insurance. This we should remember! Blue Shield was founded *by* the doctors of medicine but not *for* them. It was founded *for* the people who desire medical care and cannot afford it. The plan should attempt to provide care and not dictate to whom the subscriber should go.

Dr. David R. Murphey Jr., as president of Blue Shield, and his Advisory Board have worked closely with your Board of Governors in bringing about changes in the operation of Blue Shield. These changes have been studied carefully and reviewed from all angles, and the actions taken were for the benefit of the low income group. Blue Shield is one of the greatest bulwarks against government-controlled medicine, and we must keep it strong and active. A closer correlation between Blue Shield and the Association will result from the amendment to the Constitution and By-Laws of Blue Shield to make members of the Florida Medical Association House of Delegates active members. In this way each county medical society will have proportionate representation in Blue Shield.

Stewart Thompson Memorial

The 1954 House of Delegates approved the idea in principle and directed your President to appoint a committee to develop the Stewart Thompson Memorial Fund. I regret to report to you that this undertaking has not been completed. A survey of similar plans in other state medical associations was made, and a questionnaire designed to get opinions on key policies and principles has been sent to leaders of the Association. I am confident that in the coming year the Plan will be in operation.

Veterans' Care

The problem of veterans' care for non-service-connected disabilities has become of national importance as a threat leading to government control of medicine. Dr. Louis M. Orr, on a national level, and Dr. Frederick H. Bowen, the chairman of the Sub-Committee to the Board of Governors on Veterans Care, have been very active in discussing and informing the medical profession and the veterans' organizations of these problems.

Specialty Group Meeting Schedules

For some time it has been thought that there should be an intermingling of the specialty group meetings with the general scientific session of the Association. This year the Committee on Scientific Work, under the chairmanship of Dr. Charles J. Collins, put into effect a plan whereby some of the specialty groups are holding their meetings at a time other than on the Sunday preceding the general session, and this trial will be evaluated with interest. I am sure you are enjoying, and will continue to enjoy, the excellent scientific sessions which are arranged for your benefit.

As I said earlier, time will not permit me to mention all the chairmen and committees, and I have touched only briefly on the ones discussed. The reports of all committees, however, are to be found in your Delegates' Handbook, and I know you will recognize the thought and time that have been spent in the accomplishments recorded there.

American Medical Association Delegates

I wish to commend our delegates to the A.M.A., Drs. Orr, Reuben B. Chrisman Jr., and Herbert L. Bryans, and to express to them the appreciation of the Association for their many hours of effort in representing us on a national level. One of the highlights of the past year in Florida was the Clinical Session of the A.M.A. held in Miami. We can be very proud of that outstanding meeting in which the Dade County Medical Association and your Association had a prominent role.

Board of Governors

I should like to compliment the members of the Board of Governors, who have carried on the work of your Association since the last meeting of the House of Delegates. They have been most faithful in performing their duties and have treated our problems with much thought and care.

Executive Office

All the work of the Association hinges around our Managing Director, Mr. Gibson, and his competent force in the Executive Office. He, with Mr. Parham and Mr. Thomas R. Jarvis, and the office staff are to be thanked for their excellent and efficient efforts for the Association. Mr. Gibson has worked willingly and expertly and has cooperated to the full extent with the Board of Governors, the many committees, and the Woman's Auxiliary. May I say here that the Board of Governors appreciated the excellent services of Mrs. Mae W. Mason of the Executive Office, who has given up many a Sunday for our deliberations. Mr. Jarvis is being transferred from the Bureau of Public Relations and is being placed in charge of the new Department of Publications. This change will be of great aid and value to the Editor of The Journal, who has been for many years Dr. Shaler Richardson.

There has been a great increase in our membership and this has resulted, naturally, in increased activities and heavier demands on the Executive Office, which is operating in limited and cramped quarters. A survey was made by Dr. John D. Milton and his committee, who reported

that there was definite need for additional space which was not available in the present building. After studying Dr. Milton's report, the Board of Governors voted to recommend to the House of Delegates, first, that the Executive Office continue to be maintained in Jacksonville, and second, that a new office be authorized, this to be either an Association-owned building or a long term rental property.

Role of County Medical Society

These efforts of the Association are of great importance, but the most important factor in organized medicine is the county medical society. The state association attempts to coordinate and aid in its endeavors. We are very fortunate to have component county medical societies that are active and have taken leadership that has inspired other societies throughout the country. As an example, the Pinellas County Medical Society can point with great pride to its public forums, which have done so much to create better relations between the doctor and his patient. It is the duty of the leaders of the state and county societies to inform and inspire the individual member and to impress on him that there is strength in unity. The Dade County Medical Association, in particular, has instituted an excellent training program for its new members. Although there is strength in organization, it must be emphasized that in this same organization, one always loses some of one's individual freedom, but this sacrifice is for the welfare of the group.

I wish to urge all of our county societies to indoctrinate their new members and educate their older members as to their responsibilities concerning ethics and organized medicine. They must be taught that the national, state, and county organizations cannot carry on successfully their many projects without the individual doctor. Good public relations, which we all advocate, can be attained only by the good personal relations established by each individual doctor. The necessity for the ethical practice of medicine cannot be stressed too strongly. Criticism should not be directed at a fellow practitioner until the matter in question has been discussed with him and all the facts ascertained; then these facts should be presented to the grievance committee of the county medical society for consideration instead of being aired to the general public.

Role of the Individual Physician

Not only must good personal relations be established among the members of the medical profession itself, but also between the doctor and the patient. Our relationship with our patients must become more friendly and more personal, and we should show interest in their family and financial problems as well as their illnesses. Knowledge and understanding will result in reasonable charge for our services and through that the abolishment of the present criticism by the public concerning "high fees." As individuals, we must be fair to our insurance companies that are attempting to aid those in the low income bracket. We must realize that unfairness on our part results in higher premiums, which the low income groups cannot afford, thus defeating our efforts to make medical care available for all.

Community service is a field of endeavor in which, at times, we are sorely lacking. Not only are we doctors but citizens also with a community responsibility. We should take part in civic and charitable projects, especially those dealing with health affairs. Dr. Ashbel C. Williams, chairman of our Committee on Cancer Control, has well exemplified this type of service. He has taken leadership in the Florida Division of the American Cancer Society and, along with other outstanding members of our Association, has helped shape and formulate its policies. This is the type of leadership we need in all community projects, for who is better trained, better informed, and better able to give advice and direction than we? So let us build up our personal relationships and, as leaders in our profession, foster and encourage these ideals among our membership.

It has been a privilege to serve as your President this past year. I have been deeply honored by your trust and confidence, and have been gratified by the hard work, interest, and support I have received from you as individual members. This type of diligence and enthusiasm insures the continuation of a strong and active Florida Medical Association.

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ABSTRACTS OF MEDICAL ARTICLES

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 1018, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

The Journal of the American Medical Association is limiting its Current Medical Literature section. Thus, our main source of information on articles written by our members has been greatly curtailed.

Hamman-Rich Syndrome: Analysis of Current Concepts and Report of Three Precipitous Deaths Following Cortisone and Corticotropin (ACTH) Withdrawal. By J. Winthrop Peabody Jr., M.D., Howard A. Buechner, M.D., and Augustus E. Anderson, M.D. A. M. A. Arch. Int. Med. 92:806-824 (Dec.) 1953.

Diffuse interstitial pulmonary fibrosis of the type originally described by Hamman and Rich is here redefined in the light of subsequent reports and the personal experience of the authors. They propose "Hamman-Rich syndrome" as a more apt designation for this condition, which they define as an acute or chronic pulmonary disease of unknown etiology characterized clinically by cough, dyspnea, and cyanosis in association with minimal physical findings and a progressive, essentially afebrile course; radiographically by parenchymal reticular and nodular shadows and hilar densities, the only definitive characteristic of which is the eventual tendency toward diffuse bilateral involvement, and pathologically by an extensive fibrosis as well as a round cell and plasma cell infiltration confined to the interstitial tissue of the lung.

The 3 fatal cases reported brought the number of authentic cases recorded to 21. Of these 3, the first represented the acute fulminating form of the disease, the second, an intermediate type, and the third, the chronic variety. On the basis of 2 deaths following cortisone withdrawal and a third following a slight decrease in corticotropin (ACTH) dosage, the authors question the advisability of so treating any but the most desperately ill patients with diffuse indeterminate pulmonary fibrosis. If these endocrinal agents are utilized, a permanent maintenance dose is advocated; should withdrawal be contemplated, the utmost caution is urged.

Histochemical Localization of Succinic Dehydrogenase and Endogenous Reductase Activity in Squamous Cell Carcinoma of the Cervix. By Alvan G. Foraker and Sam W. Denham. Texas Reports on Biology and Medicine 11: 643-652 (Winter) 1953.

Succinic dehydrogenase plays a vital role in respiratory processes of most living cells and forms a link in the chain of reactions concerned with the oxidation of lipids, carbohydrates and proteins. In recent years, histochemical methods for the demonstration of succinic dehydrogenase have provided means for determining the sites of activity of this oxidative enzyme within cells and tissues. The principle of the demonstration is the observation of the change in color of a suitable hydrogen acceptor (one of the various tetrazolium salts) when it is reduced by the enzyme in the presence of a suitable substrate.

Previously the authors found evidence of dehydrogenase activity in cervical biopsies from pregnant and nonpregnant women corresponding to regions of cell growth, as in the basal layer of portio vaginalis squamous epithelium (Surg., Gynec. & Obst. 96:259-264, 1953). In the series of cervical biopsies from cases of squamous cell carcinoma here reported, succinic dehydrogenase activity and endogenous reductase activity were demonstrated within the cytoplasm of the neoplastic cells. The sites of this activity studied were in invasive squamous cell carcinoma, intraepithelial carcinoma, and metaplastic and normal portio vaginalis squamous epithelium of the cervix uteri by incubating tissue blocks in neotetrazolium. In general, manifestation of enzyme activity occurred in the basal layer of normally maturing squamous epithelium but more diffusely through the other types of epithelium. This corresponds in general to sites of cell proliferation.

Tick Paralysis (Successfully Treated in the Stage of Ataxia). By Edward Jaffe, M.D., and Irwin Perlmutter, M.D. J. Pediat. 45:98-100 (July) 1954.

Tick paralysis has been reported only a few times in the southeastern and Atlantic Coast states. First manifesting itself as an ataxia of the lower extremities, it gradually progresses to involve the upper extremities. Weakness follows and then paralysis of an ascending type. If it is still untreated, bulbar signs develop, and death ensues from respiratory failure. The diagnosis is made by discovery of the offending tick, and the treatment consists of removal of this arthropod. The central nervous system presumably is affected by a toxin elaborated by the fully engorged pregnant female tick Dermacentor andersoni or Dermacentor variabilis some 10 to 12 days after the attachment. If the patient is first seen in the stage of true weakness — after the cerebellar type picture has disappeared — the diagnosis of anterior poliomyelitis may appear to be the most obvious one.

A case is reported in a child, in which the tick was removed during the stage of ataxia, before weakness developed, with improvement beginning within a few hours. This case occurred in November in South Florida, where the year-round subtropical climate predisposes to the continuous presence of the tick, thus making the occurrence of tick paralysis possible throughout the year in this area. In this case the patient at first was suspected of having poliomyelitis.

Anaphylactoid Reaction to Penicillin. By M. M. Halpern, M.D., and Bernard Ross, M.D., Ph.D. South M. J. 47:1085-1088 (Nov.) 1954.

These authors report a series of 11 cases of nonfatal anaphylactoid reaction to penicillin collected by random questioning of approximately 50 physicians practicing in the Miami area. Their report was stimulated by an almost fatal reaction of this type in a colleague. They describe an anaphylactoid reaction as characterized by the appearance, within seconds or minutes after an injection of a shocklike state with dyspnea, tachycardia, precipitous fall in blood pressure, loss of consciousness and very occasionally a fatal termination, in contrast to the more slowly developing allergic complications of penicillin. The accepted opinion, they note, is that the allergic manifestations, including the anaphylactoid type, are due to the penicillin fraction itself rather than to any other component of the preparations which commonly have been used.

In 2 cases of their series there was clinical and electrocardiographic evidence of acute coronary insufficiency. A subsequent severe serum sickness type of reaction accompanied by the lupus erythematosis cell phenomenon occurred in 1 case.

At the time of their report they were aware of 38 other reported cases of anaphylactoid reaction to penicillin, with 12 deaths. In view of the rapidly increasing incidence of this reaction, as indicated by their survey, they suggest accurate and more frequent reporting of this type of reaction to help rectify this definite hazard with which too few physicians appear to be familiar.

"Sore Mouth" — a Problem of General Medical Interest. By A. R. Hollender, M.D., F.A.C.S. Eye, Ear, Nose & Throat Monthly 32:28-35 (Jan.) 1953.

Since more often than not pathologic processes in "sore mouth" are associated with systemic disorders, dealing with this problem makes a familiarity with general medicine not only highly advantageous but almost indispensable. Viral, bacterial and nutritional factors account for the acquired forms of lip lesions. Although gingival infections are said to be of local origin, they so frequently are associated with general disorders that the processes suggest existence of a vicious circle. Stomatitis may be (1) attributed to local factors, (2) related to systemic diseases, (3) associated with cutaneous and allergic diseases, or (4) associated with the blood dyscrasias.

Other oral infections encountered less frequently which may produce "sore mouth" are discussed under the broad classification of miscellaneous oral disease. They are to be considered from the standpoint of differential diagnosis. Halitosis and dry mouth also are discussed in so far as they relate to oral pathologic processes.

The necessity of a careful inspection of the mouth in the course of routine general physical examinations is stressed. Also, a plea is made for the prompt utilization of available laboratory procedures so that the correct diagnosis of any oral lesions will not be delayed.

Diabetes Insipidus, Diabetes Mellitus, and Insulin Resistance with Histiocytosis. By Leonard G. Rowntree, M.D., and Robert J. Poppiti, M.D. J.A.M.A. 156:310-312 (Sept. 25) 1954.

A case is reported in which a patient, under clinical observation for seven years, was treated successively and, with the passing of time, collectively for diabetes insipidus, diabetes mellitus, intercurrent infections, and insulin resistance. The existence of disseminated histiocytosis was not established, nor even suspected, during life. Repeated routine blood studies in life revealed normal values for erythrocytes and for hemoglobin. The leukocytes were normal in number and distribution, except for transient slight increases in monocytes.

At autopsy, there was evidence of pronounced bone marrow changes and widespread invasion of tissue by lipid-containing and nonlipid-containing histiocytes, which were found in the bone marrow, the posterior lobe of the pituitary gland, and other organs, and which resembled the cells in lipid histiocytosis of cholesterol type (Hand-Schüller-Christian disease). Had sternal puncture been performed, the diagnosis of histiocytosis might have been established. The authors advise sternal puncture routinely in otherwise unexplained diabetes insipidus, for 3 to 4 per cent of all cases are associated with lipid histiocytosis of cholesterol type. Since the type of cell found in this disease is relatively sensitive to irradiation, focal irradiation of the hypophysis might have proved somewhat helpful in this case, but general irradiation probably was indicated, since these abnormal cells were widely distributed throughout the body. It is suggested that there is a grave need for further study of histiocytosis and diseases associated therewith.

Moniliasis: A Review and a Report of the First Case Demonstrating the Candida Albicans in the Cornea. By David Lee Mendelblatt, M.D. Am. J. Ophth. 36:379-385 (March) 1953.

A case of invasion of the cornea by Candida albicans is reported which resulted in perforation and finally enucleation of the eye. This appears to be the first case in the literature demonstrating the fungus in the cornea and accompanied by a complete pathologic report. The literature on ocular moniliasis is reviewed, moniliasis of other organs of the body is outlined, and therapy is discussed.

In summary, the author observes that moniliasis should be suspected in nonspecific granulomas, and should not be confused with tuberculosis. Also, in microscopic sections of biopsy or autopsy material, the C. albicans should not be confused with small lymphocytes.

Studies in Toxemia, Emphasizing Mercurial Diuretic Therapy. By James W. Hendrick, M.D. Bull. Tulane M. Fac. 13:169-172 (Aug.) 1954.

Studies by the author and others associated with him indicate that mercurial diuretics are useful in minimizing the water retention occurring in the toxemias of pregnancy. In a series of 100 cases of pre-eclampsia treated with mercurial diuretics the indications for therapy were excessive gain in weight and the development of pitting edema in pregnant women. Results were graded on the basis of loss in weight and increased urinary output, or both, with the reduction in weight representing the best basis for evaluation of therapy. Analysis of individual cases revealed that good results occurred in 75 patients with an average loss of 6.7 pounds in weight, fair results in 7, and poor results in 10. In 8 patients delivery occurred so soon after the treatment was begun that it could not be evaluated. No toxic effects were noted in this series.

Studies of sodium and potassium levels in the serum, made in 39 normal pregnant patients and 29 pre-eclamptic patients, resulted in the following observations: (1) Both normal and toxemic pregnancies are associated with a lowered serum sodium level. (2) In normal pregnancy urinary sodium and potassium values are below those observed in nonpregnant women. (3) Urinary studies in pre-eclamptics disclosed an even greater tendency toward sodium and potassium retention than in normal pregnancy. Further 24 hour urine studies on 24 of the pre-eclamptic patients after injection of 2 cc. of mercurial intramuscularly demonstrated a decided increase in urinary sodium after mercurial injection, averaging 168.5 per cent more sodium than in the premercurial specimen.

On the basis of these studies, mercurial diuretics are recommended as an adjunct to therapy in cases of pre-eclampsia with sudden excessive gain in weight and pitting edema.

















CONVENTION HIGHLIGHTS

PROCEEDINGS
Eighty-First Annual Meeting

of the

FLORIDA MEDICAL ASSOCIATION
HELD AT ST. PETERSBURG
APRIL 4, 5, and 6, 1955

GENERAL SESSIONS

First General Session

The Eighty-First Annual Meeting of the Florida Medical Association was called to order at 9:30 a.m., Monday, April 4, in the Convention Hall of the Vinoy Park Hotel, St. Petersburg, Florida, by President Duncan T. McEwan.

Invocation was pronounced by The Reverend Paul R. Hortin, D.D., Pastor, Christ Methodist Church, St. Petersburg.

Our Father, at the beginning of this busy day, we pause to invoke Thy blessing.

Thou hast given us the day, and Thou hast created us and not we ourselves.

We rejoice that regarding our bodies and brains Thou hast given us skill in thinking Thy thoughts of health and healing after Thee.

We thank Thee for physicians who have spared us from pestilence and epidemics—and whose presence at our bedsides is sweet with certainties.

Physicians who have gone with our youth into the Armed Forces, and with our loved ones into the valley of the shadow.

Men with healing in their hands who are pillars in their churches and civic-minded in their communities.

We pray

(1) For the physician's own family, so oft neglected to care for our families.

(2) For their own little children to whom they gladly owe an affectionate and happy responsibility superceding all other claims on their time.

(3) For their stalwart sons and lovely daughters in college and beyond.

(4) For their dear faithful wives and helpmates — often by the call of duty denied the desired presence of their physician husbands — yet understanding and carrying on.

To such, may these days in St. Petersburg afford some holiday nuptial bliss and joyous recreation.

Father, watch over the deliberations and decisions of this state convention. Give the officers special reserves of strength and wisdom. Reward them and all others for work they have done in preparation for this important meeting.

For all mankind we pray. Give sense to cruel men in the Kremlin that they at least may be more cautious, if not Christian. Grant

Convention Highlights (Opposite)

(1) Dr. John D. Milton of Miami (left), newly installed president of the Florida Medical Association, pins the past president's button on the lapel of Dr. Duncan T. McEwan of Orlando. (2) At the patio party are Dr. and Mrs. McEwan (left) and Dr. and Mrs. C. Frank Chunn of Tampa. (3) A group of delegates listen to proceedings of the House. (4) Dr. Shaler Richardson of Jacksonville, editor of The Journal, receives his delegate's badge. (5) Dr. Clyde O. Anderson, president of the Pinellas County Medical Society, welcomes Association members to St. Petersburg for the 81st annual meeting. (6) Registering for the Convention are Dr. Lorenzo L. Parks of Jacksonville (left) and Dr. Eugene B. Maxwell of Tampa. (7) Dr. Milton congratulates Dr. Francis H. Langley of St. Petersburg following the selection of Dr. Langley as president-elect. (8) Dr. McEwan and Dr. Samuel M. Day of Jacksonville confer following the reelection of Dr. Day as secretary-treasurer.

health and wisdom to our President, our Governor, our Mayor, and the presiding officers of this convention, and bring us all at eventide Home to eternal rest and reward.

In the name of our Great Physician Who taught us to pray,

"Our Father Who art in Heaven . . ."

Amen.

President McEwan introduced The Honorable Samuel G. Johnson, Mayor of St. Petersburg.

Mr. Johnson: "President McEwan, Ladies and Gentlemen: We are indeed honored to have you here in our city for your Eighty-First Annual Meeting. This Association is several years older than I and even a few years older than this city, but I do not believe there is a doctor present—there may be one—but I do not believe there is a doctor present who attended the first meeting of the state medical association. However, you know that we are particularly pleased and honored to have the Florida Medical Association in convention in our city and I am sure that I can call upon each of the local doctors to assure you on my behalf that you are our guests.

"Your President just mentioned the weather. I think anyone in any city in Florida can make a promise that tomorrow the weather will be good because usually it is. It is a little different here in St. Petersburg. If we have a nasty morning, we can usually promise it will clear off in the afternoon. Then when it starts in the afternoon, we can say it will clear in the evening and tomorrow will be bright.

"We hope your meeting here will be very pleasant in every way and that it will be entirely successful. I wish you to know, Mr. President, that I am extremely honored to be recognized and to appear before such a fine, distinguished and outstanding group.

"You are always welcome in St. Petersburg and I hope, and express the hope in behalf of the city, that you will return in the near future and that your visits will be frequent. We have a little custom here in St. Petersburg of recognizing distinguished and outstanding visitors and I take this opportunity to so recognize your President, Dr. McEwan. This will have to be a sort of token presentation, Doctor, because we have had so many visitors our supply of gifts has long been depleted. They have been reordered and are in transit and I assure you, Dr. McEwan, that yours will be the first to be transmitted to you upon receipt of the new order. I am speaking about a small article of jewelry, representing the key to the City of St. Petersburg. That token will certainly always assure you a delightful and genuine welcome to the City of St. Petersburg. It will always get you into the city and your leaving will be at your descretion and desire.

"At this moment, Doctor, I offer my hand in token of that award from the City of St. Petersburg and assure you, and all the members of the Florida Medical Association, that you are always truly welcome to the City of St. Petersburg."

Dr. McEwan: "Thank you, sir. I am sure that we need no keys, because I know the City is open to us. Thank you for being here, and thank you for your hospitality."

Dr. McEwan introduced Dr. Clyde O. Anderson, President, Pinellas County Medical Society.

Dr. Anderson: "Dr. McEwan, Dr. Hortin, Mayor Johnson, Members of the Florida Medical Association, Guests and Ladies: On behalf of the Pinellas County Medical Society, I bid you welcome. We sincerely hope the meeting will be most pleasant. We would like to do everything possible to see that this meeting is successful. It has been many years since you were here. We would like to have you come back and we will make every effort to see that the meeting is brought back here.

"I feel that it is an honor and a privilege to have you here and we will certainly enjoy having the members decide to return here at a future date. With this in mind, Dr. McEwan, I would like to state that Pinellas will go all out at any time to help with this meeting."

Dr. McEwan: "Thank you, Clyde. We are happy to be in St. Petersburg and I am sure we are going to have a very successful meeting."

"Dr. J. W. Chambers of LaGrange, Georgia was appointed a fraternal delegate from the State of Georgia, and had planned to be here. However, we have a letter of regret from Dr. Chambers."

"We are honored to have with us the President of the Medical Association of Georgia, Dr. Peter B. Wright."

Dr. Wright: "Dr. McEwan, I am happy to be here and bring you Greetings from the Medical Association of Georgia."

Dr. McEwan: "We are happy to have you here, Dr. Wright."

"The City of St. Petersburg has extended special parking privileges to the doctors during this meeting. Identification tags for your automobiles are available at the Information Desk in the lobby. If any of you should receive a

parking ticket, please turn it in at the Registration Desk."

President McEwan made announcements about the scientific and technical exhibits, the shuttle bus to the Soreno Hotel, and the Woman's Auxiliary luncheon.

There being no further business, the meeting adjourned at 9:45 a.m.

Second General Session

The Second General Session of the Florida Medical Association convened at 11:30 a.m., Tuesday, April 5, in the Convention Hall of the Vinoy Park Hotel, St. Petersburg; President McEwan in the Chair.

Dr. McEwan: "It is my privilege this morning to present as our guest speaker at this Eighty-First Annual Meeting one of my very closest personal friends. He was born and reared in Kentucky, received his A. B. degree from Bethel College and his M.D. from the University of Kansas. Following his internship at the Kansas City General Hospital and residency at the Wesley Hospital in Kansas City, he became surgical assistant to the well-known surgeon, Dr. W. J. Frick of Kansas City. He did graduate work at the Washington University School of Medicine in St. Louis, the Harvard Medical School in Boston, the University of Montpelier in France and the University of Vienna in Austria.

"He is well known to all of you by his writing and his work. He is a former chairman of the Section on Surgery of the Southern Medical Association. He has had the distinct honor of being President of the American Goiter Association and has done outstanding work in goiter surgery. He has had widely published articles on abdominal surgery. He has devised original operations with which I am sure you are all familiar and this morning he is going to talk to us on gallbladder problems, which he is eminently qualified to do. It is my privilege and honor to present to you my good friend and a noted surgeon, Dr. Claude Hunt of Kansas City."

Address: "Gallbladder Problems," by Dr. Claude J. Hunt.

Dr. Hunt: "I want to thank all of you for your kind attention, and above all, Dr. McEwan for inviting me."

Dr. McEwan: "Thank you very much, Dr. Hunt. I am sure we have been amply rewarded by hearing Dr. Hunt. I have never heard a more scholarly and interesting presentation of gallbladder problems."

There being no further business, the meeting adjourned at 12:30 p.m.

ARE YOU MOVING?

Please send the following to: Florida Medical Association, P.O. Box 1018, Jacksonville, Fla.

Name .....
(Please print)

Old Address:

Street .....

City & Zone .....

State .....

New Address:

Street .....

City & Zone .....

State .....

First House of Delegates

The House of Delegates convened at 9:40 a.m., Tuesday, April 5, 1955 in the Convention Hall of the Vinoy Park Hotel, St. Petersburg, Florida, with Dr. Duncan T. McEwan, President in the Chair.

Dr. Louis M. Orr, Chairman of the Credentials Committee, announced that a quorum was present. (Subsequent report of the Credentials Committee showed 138 delegates registered.)

Dr. C. Frank Chunn of Hillsborough moved that the Delegates be seated.

Seconded by Dr. Ralph Herz of Monroe.

Motion carried.

Delegates

ALACHUA—F. Emory Bell, John E. Maines Jr., Walter E. Murphree

BAY—William C. Roberts

BREVARD—Thomas C. Kenaston

BROWARD—Fred E. Brammer, Burns A. Dobbins Jr., Donald H. Gahagen, Richard A. Mills, Paul G. Shell, Curtis H. Sory

COLUMBIA—Laurie J. Arnold Jr.

DADE—Edward R. Annis, Reuben B. Chrisman Jr., Jack Q. Cleveland, Francis N. Cooke, Edward W. Cullipher, Robert F. Dickey, L. Washington Dowlen, Franklin J. Evans, Willard L. Fitzgerald, W. Tracy Haverfield, R. Spencer Howell, James J. Hutson, Ralph W. Jack, Paul S. Jarrett, Walter C. Jones, Alfred G. Levin, A. Buist Litterer, Donald F. Marion, C. Russell Morgan Jr., Homer L. Pearson Jr., Kenneth Phillips, Warren W. Quillian, Jack O. W. Rash, Hunter B. Rogers, Walter W. Sackett Jr., Oden A. Schaeffer, Franz H. Stewart, Joseph S. Stewart, Richard F. Stover, William M. Straight, Harrison A. Walker, Edward H. Williams, Corren P. Youmans

DeSOTO-HARDEE-HIGHLANDS-GLADES—Donald C. Hartwell

DUVAL—James L. Borland, Hugh A. Carithers, Turner Z. Cason, A. Judson Graves, Karl B. Hanson, Edward Jelks, F. Gordon King, Raymond H. King, Joseph J. Lowenthal, Kenneth A. Morris, Sidney Stillman, G. Dekle Taylor, W. W. Rogers, Leo M. Wachtel Jr.

ESCAMBIA—Paul F. Baranco, Herbert L. Bryans, Luther C. Fisher Jr., Alvin L. Stebbins, Gretchen V. Squires

FRANKLIN-GULF—Harold B. Canning

HILLSBOROUGH—Frank S. Adamo, Chas. W. Bartlett, Leffie M. Carlton Jr., C. Frank Chunn, Herschel G. Cole, H. Phillip Hampton, Linus W. Hewit, Samuel G. Hibbs, William M. Rowlett

INDIAN RIVER—Kip G. Kelso

JACKSON-CALHOUN—Jabe A. Breland

LAKE—C. McK. Tyre

LEE-CHARLOTTE - COLLIER - HENDRY—William H. Grace, H. Quillian Jones

LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON—Francis T. Holland, J. Lloyd Massey, Robert H. Mickler

MADISON—*(Absent—Wallace E. Winter)*

MANATEE—Millard P. Quillian

MARION—Eugene G. Peek Jr.

MONROE—Ralph Herz

NASSAU—Henry B. Dickens Jr.

ORANGE—Frank C. Bone, James B. Glanton, Eugene L. Jewett, Walter B. Johnston, Carl S. McLemore, Louis M. Orr, Frank J. Pyle, Adelbert F. Schirmer, W. Dean Steward

PALM BEACH—Edwin W. Brown, C. Jennings Derrick, Charles McD. Harris Jr., Walter R. Newbern, Ralph M. Overstreet Jr., Cecil M. Peek, Raymond S. Roy

PASCO-HERNANDO-CITRUS—S. Carnes Harvard

PINELLAS—Clyde O. Anderson, William M. Davis, N. Worth Gable, Everett M. Harrison, Francis H. Langley, Alvin L. Mills, Daniel F. H. Murphey, John P. Rowell, James E. Thompson, Walter H. Winchester

POLK—Jere W. Annis, James R. Boulware Jr., Samuel J. Clark, Marion W. Hester

PUTNAM—Grover C. Collins

ST. JOHNS—A. Clark Walkup

ST. LUCIE-OKEECHOBEE-MARTIN—John M. Gunsolus

SARASOTA—John M. Butcher, Hugh G. Reaves, Melvin M. Simmons

SEMINOLE—Daniel H. Mathers

SUWANNEE—Edward G. Haskell Jr.

TAYLOR—*(None submitted)*

VOLUSIA—C. Robert DeArmas, Carroll V. Herron, Achille A. Monaco *(Absent—Morris B. Seltzer)*

WALTON-OKALOOSA—William D. Cawthon

WASHINGTON-HOLMES—Martin L. Lane

STATE OFFICERS—Duncan T. McEwan, John D. Milton, V. Marklin Johnson, Frederick H. Bowen, Rowland E. Wood, Samuel M. Day, Shaler Richardson

On motion by Dr. Franz H. Stewart, seconded by Dr. William M. Rowlett, the minutes of the Eightieth Annual Session as published in the June 1954 Journal were approved.

President McEwan introduced several honored guests: Mrs. George Turner, President of the Woman's Auxiliary to the American Medical Association, Mrs. Richard F. Stover, President of the Woman's Auxiliary to the Florida Medical Association, and Mrs. Samuel S. Lombardo, President-Elect of the Woman's Auxiliary to the Florida Medical Association.

President McEwan asked Dr. V. Marklin Johnson, First Vice President, to take the Chair.

Dr. Johnson: "Members of the Florida Medical Association, Members of the Woman's Auxiliary, and Guests: The By-Laws of the Association provide that at this session of the House of Delegates we shall be honored by the President's address. I have always felt that this gives to you an excellent means of being briefed in what we might call the efforts and acomplishments of our Association. We shall have the pleasure and privilege of hearing from our President, Dr. Duncan McEwan."

Dr. McEwan delivered his presidential address. (The complete text may be found in this Journal on page 1015.)

At the end of the address, the members rose in unison and applauded.

Dr. Johnson: "Duncan, that was a job well done and I am sure we are all much wiser."

President McEwan resumed the Chair.

President McEwan called for nominations for one delegate and one alternate to the House of Delegates of the American Medical Association.

The Chair recognized Dr. Walter C. Jones of Dade.

Dr. Jones: "Members of the House of Delegates, it is a pleasure for me to place in nomination for re-election the name of the man who has so ably served us during past years. We need no reiteration of his activities in the House of Delegates. If nothing else, the work he has done as chairman of the Federal Medical Services Committee justifies his renomination. It has been a pleasure to watch his activities in the State Association and to see how well he has conducted himself on a national level.

"I take great pleasure in nominating Dr. Louis M. Orr for re-election as our delegate for another two years."

Dr. Thomas C. Kenaston of Brevard: "Brevard County is honored to second the nomination of Dr. Orr."

Dr. Richard A. Mills: "I move that nominations be closed and the secretary cast a unanimous ballot for Dr. Orr."

Motion seconded and carried.

Dr. William M. Rowlett: "For alternate delegate, I would like to nominate a man who is known as the 'old warrior' of our Association. For years he has attended every meeting of the A.M.A. and is highly eligible to perform any duty for which he might be called. It gives me great pleasure to nominate Dr. Joshua C. Dickinson."

Dr. Burns A. Dobbins Jr.: "I would like to nominate Dr. Richard A. Mills of Broward County. He is a past president of the Broward County Medical Association. He is a regular attendant at all AMA meetings, is a member of the scientific assembly of the American Medical Association and of the General Practice Section. He is well qualified to represent us as alternate delegate to that body."

The Chair ruled that a secret ballot was in order and appointed Drs. L. Washington Dowlen, Thomas C. Kenaston and James L. Borland as tellers.

After Dr. Dowlen reported the result of the secret ballot, the Secretary announced that Dr. Richard A. Mills had been elected as alternate delegate to the American Medical Association.

Dr. McEwan read the personnel of the three reference committees, as follows:

1. HEALTH AND EDUCATION
Room A
Warren W. Quillian, Chairman
Jere W. Annis
Frederick H. Bowen
N. Worth Gable
Burns A. Dobbins Jr.

2. PUBLIC POLICY
Room B
Edward Jelks, Chairman
William C. Roberts
H. Phillip Hampton
Robert F. Dickey
Francis H. Langley

3. FINANCE AND ADMINSTRATION
TV Room
John D. Milton, Chairman
Samuel M. Day
Francis T. Holland
Edward R. Annis
W. Dean Steward

Dr. A. Buist Litterer read his report as Chairman of the Venereal Disease Control Committee. This report had been received too late to be printed in the Handbook.

The Secretary read the report of the Committee on Tuberculosis and Public Health by Dr. John G. Chesney, Chairman, which had been received too late for publication in the Handbook.

Dr. Sullivan G. Bedell read his annual report as Chairman of the temporary Mental Health Committee.

The Chair recognized Dr. H. Phillip Hampton, Chairman, Committee on Legislation and Public Policy.

Dr. Hampton: "The House of Delegates in April 1954 authorized the Board of Governors to request the Governor of Florida to appoint a commission to study the problem of hospitalization of the indigent in Florida and make recommendations for a legislative act to provide hospitalization for the indigent.

"Your committee, upon authorization from the Board, discussed the proposal with Governor Nominee LeRoy Collins, who appointed an unofficial Committee on Indigent Hospitalization in July 1954 to study the problem.

"This Commitee was composed of: George T. Harrell Jr., M.D., Dean, College of Medicine, University of Florida; Charles C. Hillman, M.D., Executive Director, Jackson Memorial Hospital; Rep. J. B. Hopkins, Group 1, Escambia County, State of Florida; Ralph W. Jack, M.D., Past President, Dade County Medical Association; Edward Jelks, M.D., Member, Board of Governors, Florida Medical Association; Earl L. Koos, Ph.D., School of Social Welfare, Florida State University; Mr. T. Fletcher Little, Administrator, Halifax District Hospital; Robert B. McIver, M.D., Member, Board of Governors, Florida Medical Association; John M. Maclachlan, Ph.D., Head Professor, College of Arts & Sciences, University of Florida; Senator Verle A. Pope, District 31, State of Florida; Wilson T. Sowder, M.D., State Health Officer, State of Florida; Robert T. Spi-

cer, M.D.,[1] Dean, Medical School, University of Miami; Mr. S. Tanner Stafford,[2] Administrator, Florida A & M College Hospital; H. Phillip Hampton, M.D., Chairman, Committee on Legislation & Public Policy, Florida Medical Association.

"This Committee was officially appointed by Governor Collins in January 1955 and requested to submit its report at the earliest possible date.

"The Committee made as complete a study as possible in the time available and submitted its report on February 1, 1955 to the Governor.

"The Committee recommended:

"1. Under provisions of the Florida Constitution, Article XIII, Section 3, the State Legislature by general law should provide a uniform system for hospitalization of the indigent by creating a state fund out of which payments may be made directly to hospitals for the costs of caring for certified indigent.

"2. Fifty per cent of the fund should be provided by the state from general revenues and fifty per cent from county matching funds. The total amount of the fund should not be less than one dollar per capita per year.

"3. Counties should be eligible to receive monies from the state portion of this fund only after expending an equal amount for hospitalization of the indigent and may not exceed their per capita share of the state fund. Payment for the costs of providing hospital care for acutely ill indigent by approved hospitals should be paid from the portion of the state fund due the county of residence of the indigent.

"4. The state should not intend or be obligated to provide hospitalization for all indigent of the state through the fund created by this act, and the administration of this fund should not interfere with existing or future county plans for providing hospital and medical care for their indigent.

"5. The funds created by this act should be used primarily to pay hospitals for care of acutely ill indigent and first priority for payment should be given to reimburse hospitals for the cost of hospital care provided acutely ill indigent not resident in that county. Each county should be encouraged to provide and finance its own facilities for the chronically ill.

"6. An adequate amount of the state fund should be held in reserve to provide for hospital care of out-of-state indigent and this act should provide for the acceptance and use of federal funds in the event they become available for hospital care.

"7. The act creating this fund should outline the purposes for which the fund is created and the general manner in which it shall be administered, leaving the details of administration to regulation of the administering state agency.

"8. The determination of indigency of an individual receiving hospital or medical care should be by the usual agency performing that service in the county of residency of the indigent providing that agency is approved by the State Board of Health.

"9. The administering state agency shall approve the county agency, preferably with medical personnel who can cooperate with local and county physicians and agencies in determining need for hospitalization, indigency and disposition of the indigent sick. The State Board of Health is the only agency which seems qualified to handle this program.

"10. An advisory committee for administration of this state fund for indigent hospitalization should be appointed representing all agencies and professions which will be concerned with this program, including the public, hospital administrators and the medical profession.

"The Governor has arranged for a bill to be drafted to accomplish the recommendations of the Committee and agreed to sponsor this legislation in the 1955 Session of the Florida Legislature.

"Your Committee requests the approval in principle of this program for Hospitalization of the Indigent in Florida."

The Chair announced that resolutions from the floor would be heard at this time.

Dr. Burns A. Dobbins Jr. of Broward presented a resolution on free medical care for state legislators. This was referred to Reference Committee No. 2, Public Policy.

Dr. Dobbins also presented a resolution on re-examination for non-resident licensed practitioners after five years of absence from the state. This was referred to Reference Committee No. 1, Health and Education.

Dr. Herbert L. Bryans presented a resolution by the Escambia County Medical Society requesting the formation of a standing Committee on Nursing. This was referred to Reference Committee No. 3, Finance and Administration.

Dr. Eugene G. Peek Jr. presented a resolution on treatment of non-service-connected tuberculosis by the Veterans Administration. This was

1. Resigned November 7, 1954, due to ill health.
2. Resigned November 7, 1954, moved from state.

referred to Reference Committee No. 1, Health and Education.

Dr. Adelbert F. Schirmer of Orange presented a resolution concerning the formation of a state Committee on Blood. This was referred to Reference Committee No. 3, Finance and Administration.

Dr. Schirmer also presented a resolution by the Orange County Medical Society on the Physical Therapist Practice Act. This was referred to Reference Committee No. 2, Public Policy.

Dr. Schirmer presented a resolution from the Juridial Committee of the Florida Society of Anesthesiologists regarding the opinion of the Attorney General on the legality of hospitals hiring doctors. This was referred to Reference Committee No. 2, Public Policy.

As an individual, Dr. Schirmer presented a resolution commending Governor Collins for his study of the problem of hospitalization of the indigent in Florida. This was referred to Reference Committee No. 2, Public Policy.

Dr. Edward W. Cullipher of Dade presented a resolution expressing gratitude for the opportunity of entertaining the American Medical Association at its 1954 Clinical Session. This was referred to Reference Committee No. 3, Finance and Administration.

Dr. James L. Borland of Duval presented a resolution requesting the formation of a permanent committee for Health and Accident Insurance. This was referred to Reference Committee No. 2, Public Policy.

Dr. Borland also submitted a resolution requesting Blue Shield to change its Charter or By-Laws to permit nominations from the floor for members of the Board of Directors at its annual meeting. This was referred to Reference Committee No. 3, Finance and Administration.

Dr. Cecil M. Peek of Palm Beach presented a resolution requesting certain changes in the By-Laws of the Blue Shield. This was referred to Reference Committee No. 3, Finance and Administration.

Brevard County Medical Society Resolution—Blue Shield of Florida, Inc. indemnifying nonparticipating physicians (Handbook) was referred to Reference Committee No. 3.

The following committee reports were referred as published in the Handbook:

(To Reference Committee No. 1)

Scientific Work, Chas J. Collins
Medical Postgraduate Course, Turner Z. Cason*
Cancer Control, Ashbel C. Williams
Venereal Disease Control, A. Buist Litterer
Tuberculosis and Public Health, John G. Chesney
Maternal Welfare, E. Frank McCall
Child Health, Warren W. Quillian*
*Supplemental report presented and referred

(To Reference Committee No. 2)

Conservation of Vision, G. Tayloe Gwathmey
Legislation and Public Policy, H. Phillip Hampton
Medical Education and Hospitals, Jack Q. Cleveland
Medical Economics, Robert E. Zellner*
State Controlled Medical Institutions, Samuel G. Hibbs
Representatives to Industrial Council, Chas. L. Farrington
Grievance, Walter C. Payne Sr.
*Supplemental report presented and referred

(To Reference Committee No. 3)

Board of Governors, Duncan T. McEwan*
Necrology, Alvin L. Stebbins*
Advisory to Woman's Auxiliary, Wiley M. Sams
Councilor Districts and Council, Francis H. Langley
Advisory to Selective Service for Physicians and Allied Specialists, J. Rocher Chappell
Emergency Medical Service, James V. Freeman
Resolution: Blue Shield of Florida, Inc.—Brevard County Medical Society
*Supplemental report presented and referred

There being no further business, the House of Delegates recessed at 11:25 a.m. to reconvene at 10:30 a.m., Wednesday, April 6, 1955.

Second House of Delegates

The House of Delegates reconvened at 10:30 a.m. on Wednesday, April 6, 1955 in the Convention Hall of the Vinoy Park Hotel, St. Petersburg, President Duncan T. McEwan in the Chair.

Dr. Louis M. Orr, Chairman of the Credentials Committee, was recognized and reported that a quorum was present. (Subsequent report of the Credentials Committee showed 128 delegates registered.)

Delegates

ALACHUA—F. Emory Bell, John E. Maines Jr., Walter E. Murphree

BAY—William C. Roberts

BREVARD—Thomas C. Kenaston

BROWARD—Fred E. Brammer, Burns A. Dobbins, Donald H. Gahagen, Richard A. Mills, Paul G. Shell, Curtis H. Sory

COLUMBIA—Laurie J. Arnold Jr.

DADE—Edward R. Annis, Reuben B. Chrisman Jr., Jack Q. Cleveland, Francis N. Cooke, Edward W. Cullipher, Robert F. Dickey, L. Washington Dowlen, Franklin J. Evans, Willard L. Fitzgerald, W. Tracy Haverfield,

R. Spencer Howell, James J. Hutson, Ralph W. Jack, Paul S. Jarrett, Walter C. Jones, A. Buist Litterer, Donald F. Marion, C. Russell Morgan Jr., Homer L. Pearson Jr., Kenneth Phillips, Warren W. Quillian, Hunter B. Rogers, Walter W. Sackett Jr., Oden A. Schaeffer, Franz H. Stewart, Joseph S. Stewart, Richard F. Stover, William M. Straight, Harrison A. Walker, Edward H. Williams, Corren P. Youmans *(Absent—Alfred G. Levin, Jack O. W. Rash)*

DeSOTO-HARDEE-HIGHLANDS-GLADES—Donald C. Hartwell

DUVAL—James L. Borland, Hugh A. Carithers, Turner Z. Cason, A. Judson Graves, Karl B. Hanson, Edward Jelks, F. Gordon King, Raymond H. King, Joseph J. Lowenthal, Kenneth A. Morris, Sidney Stillman, G. Dekle Taylor, W. W. Rogers, Leo M. Wachtel Jr.

ESCAMBIA—Paul F. Baranco, Herbert L. Bryans, Luther C. Fisher Jr., Alvin L. Stebbins, Gretchen V. Squires

FRANKLIN-GULF—Harold B. Canning

HILLSBOROUGH—Frank S. Adamo, Chas. W. Bartlett, Leffie M. Carlton Jr., C. Frank Chunn, Herschel G. Cole, H. Phillip Hampton, Linus W. Hewit, Samuel G. Hibbs, William M. Rowlett

INDIAN RIVER—Kip G. Kelso

JACKSON-CALHOUN—Jabe A. Breland

LAKE—C. McK. Tyre

LEE-CHARLOTTE-COLLIER-HENDRY — William H. Grace, H. Quillian Jones

LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON —Francis T. Holland, J. Lloyd Massey, Robert H. Mickler

MADISON—*(Absent—Wallace E. Winter)*

MANATEE—Millard P. Quillian

MARION—Eugene G. Peek Jr.

MONROE—Ralph Herz

NASSAU—*(Absent—Henry B. Dickens Jr.)*

ORANGE—Frank C. Bone, James B. Glanton, Eugene L. Jewett, Walter B. Johnston, Carl S. McLemore, Louis M. Orr, Frank J. Pyle, W. Dean Steward *(Absent—Adelbert F. Schirmer)*

PALM BEACH—Edwin W. Brown, C. Jennings Derrick, Walter R. Newbern, Ralph M. Overstreet Jr., Cecil M. Peek, Raymond S. Roy *(Absent—Charles McD. Harris Jr.)*

PASCO-HERNANDO-CITRUS—*(Absent—S. Carnes Harvard)*

PINELLAS—Clyde O. Anderson, William M. Davis, N. Worth Gable, Everett M. Harrison, Francis H. Langley, Daniel F. H. Murphey, John P. Rowell, James E. Thompson, Walter H. Winchester *(Absent—Alvin L. Mills)*

POLK—Jere W. Annis, James R. Boulware Jr., Samuel J. Clark, Marion W. Hester

PUTNAM—Grover C. Collins

ST. JOHNS—A. Clark Walkup

ST. LUCIE-OKEECHOBEE-MARTIN—John M. Gunsolus

SARASOTA—John M. Butcher, Hugh G. Reaves, Melvin M. Simmons

SEMINOLE—Daniel H. Mathers

SUWANNEE—Edward G. Haskell Jr.

TAYLOR—*(None submitted)*

VOLUSIA—C. Robert DeArmas, Carroll V. Herron, Achille A. Monaco *(Absent—Morris B. Seltzer)*

WALTON-OKALOOSA—*(Absent—William D. Cawthon)*

WASHINGTON-HOLMES—*(Absent—Martin L. Lane)*

STATE OFFICERS—Duncan T. McEwan, John D. Milton, Frederick H. Bowen, Rowland E. Wood, Samuel M. Day, Shaler Richardson *(Absent—V. Marklin Johnson)*

Dr. McEwan introduced Dr. Elmer Hess, President-Elect of the American Medical Association. He extended to Dr. Hess the privilege of the floor at any time.

Report of Reference Committee No. 1

The Chair called for the report of Dr. Warren W. Quillian, Chairman of Reference Committee No. 1, Health and Education. This committee was composed of Drs. Jere W. Annis, N. Worth Gable, Frederick H. Bowen and Burns A. Dobbins Jr.

Dr. Quillian: "Reference Committee No. 1 on Health and Education met yesterday with a full quota of committee members present.

"The resolution by the Broward County Medical Association requesting legislation requiring re-examination for non-resident practitioners after five years of absence from the state, presented by Dr. Burns A. Dobbins Jr. was disapproved with the following recommendation: That the resolution be referred to the Committee on Legislation for further study and collaboration with the State Board of Medical Examiners to the end that flagrant abuses of the privileges of medical practice in this state be mitigated.

"I move the resolution be disapproved and not published in The Journal."

Seconded by Dr. Chas. W. Bartlett.

Motion carried.

Dr. Quillian: "The resolution on treatment of non-service-connected tuberculosis presented by Dr. Eugene G. Peek Jr. is approved as read. Dr. Louis M. Orr, Delegate to the American Medical Association, was present and participated actively in the discussion.

"I move this resolution be adopted."

Seconded by Dr. Milton.

Motion carried.

Resolution

WHEREAS, the American Medical Association is on record as being opposed to the admission of veterans to veterans administration facilities for treatment of non-service-connected disabilities, with the exception of veterans with wartime service suffering from tuberculosis or neuro-psychitric disorders of non-service-connected origin, who are unable to defray the expense of necessary hospitalization, provided that treatment is given within the limits of existing facilities.

AND WHEREAS, these exceptions were made in the case of tuberculosis and neuro-psychiatric disorders primarily because of the shortage at the time of civilian facilities for the care and treatment of these diseases.

AND WHEREAS, in the case of tuberculosis great strides have been made in its care and treatment, through the discovery and increased use of anti-tuberculosis drugs, which has shortened the hospital stay, and made additional hospital beds available for the admission of citizens suffering from this disease.

NOW THEREFORE BE IT RESOLVED, that the American Medical Association be requested to re-examine its policy concerning veterans with wartime service suffering from tuberculosis of non-service origin on the basis of a survey of existing civilian facilities.

Respectfully submitted,
Eugene G. Peek Jr.

Dr. Quillian: "The report of the Committee on Scientific Work, presented by Dr. Chas. J. Collins, is approved with the following suggestions: That the Committee during the coming year evaluate the success of the experimental inclusion of specialty group programs with the general scientific sessions, and we earnestly request the membership of the F.M.A. to show more active interest in the formulation of the scientific program. It is felt that the wealth of talent available among the members of the Florida Medical Association justifies the belief that interesting presentations on well diversified subjects should be easily obtained from the membership at large.

"I move the report be adopted."

Seconded by Dr. Jack Q. Cleveland.

Motion carried.

Report of Committee on Scientific Work

Chas. J. Collins, *Chairman*

While the State Specialty Societies are not a component of the Florida Medical Association, the Scientific Work Committee was authorized this year to extend these groups an invitation to hold their meetings during the session of the State Association instead of pre-conventionally as has been done in the past. This was in line with the thinking of many members of the Association that the quality of the program could be improved in this manner by giving them some choice in the selection of the papers in which they were most interested. It was felt that this might ultimately lead to the merging of some of the Specialty Societies into sections of the Association at the state meeting, while maintaining their identity at other scheduled meetings. This invitation was accepted by five of the Societies and accordingly their meetings have been integrated into the first two days of the meeting and the talent of their guest speakers utilized for the scientific assemblies.

For the first time the programs of two of the Specialty Societies have been scheduled on one of the scientific assemblies. This will take the form of a joint symposium by the Florida Pediatric Society and the Florida Obstetric and Gynecologic Society during the third scientific assembly. It is hoped that the success of this venture will justify its repetition in future programs.

The Scientific Work Committee met in Orlando, Nov. 21, 1954, at which time the final program was formulated. The entire Committee was present for the meeting. From the splendid material submitted, nine papers, two case reports and six distinguished guest speakers were selected for the program. It was felt that the four scientific assemblies would be interesting, educational and well diversified and maintain the high standard that has been set for the program in recent years.

The Committee regrets it was not able to accept all the papers submitted. All were of excellent quality and it is hoped that all that could not be fitted into the program will be re-submitted next year. We are very grateful to the members who applied for places on the program and appreciate this evidence of their interest in its success. The Chairman wishes to sincerely thank each member of his Committee who, without exception, worked faithfully and earnestly in the preparation of the program.

Respectfully submitted,
Chas. J. Collins, *Chairman*

Dr. Quillian: "The report of the Committee on Cancer Control, presented by Dr. Ashbel C. Williams, is approved as published in the Handbook.

"I move the report be adopted."

Seconded by Dr. Donald H. Gahagen.

Motion carried.

Report of Committee on Cancer Control

Ashbel C. Williams, *Chairman*

The Cancer Control Committee has worked in conjunction with the Florida Cancer Council, thus assuring a complete liaison with the various organizations in Florida which are a part of the cancer control program.

In the field of professional education there were two noteworthy events: (1) The Southeastern States Cancer Seminar held in Miami and (2) The Cross Roads Seminars which were held in eight different communities.

The American College of Surgeons will require as of Dec. 31, 1955, that each tumor clinic maintain a cancer registry of all cancer cases if that tumor clinic is to receive the approval of the College. Due note has been taken of this requirement and the various tumor clinics in the state advised through the Florida Cancer Council.

The need for wider and more frequent use of cytology in cancer diagnosis is recognized. The Florida Society of Pathologists was asked to cooperate in broadening and improving statewide cytology facilities. The physicians of the state will be encouraged to use cytological diagnosis.

Because of the acknowledged necessity of routine chest X-rays in the diagnosis of early lung cancer, approval was given to the joint participation of the Florida Division of the American Cancer Society in the mass chest X-ray screening program now being conducted by the Florida State Board of Health and the Florida Tuberculosis and Health Association.

To further react against the rapid rise in lung cancer in Florida, approval was given to the general principle of taking routine chest X-rays on all hospital admissions.

Respectfully submitted,
Ashbel C. Williams, *Chairman*

Dr. Quillian: "The report of the Committee on Venereal Disease Control presented by Dr. A. Buist Litterer is approved as read.

"I move the report be adopted."

Motion seconded and carried.

Report of Committee on Venereal Disease Control

A. Buist Litterer, *Chairman*

It is gratifying to report that your State Board of Health has been able to maintain its entire venereal disease program in spite of a reduction of $250,000 in Federal funds this past year.

The cooperation between the private physician and the Board of Health in reporting cases has been very good. Greater numbers of reporting physicians are utilizing the facilities of contact follow-up available at the Board of Health which we consider the most effective method of case finding. All physicians should take advantage of this excellent service in VD control.

The Board of Health has increased its educational programs in the schools and to the public. County medical societies and many military establishments in the state have provided excellent programs to stimulate interest in this problem. The mass blood testing survey for syphilis in the Jacksonville and Miami area was completed the latter part of 1954. This method of VD control, although less effective than contact follow-up and education, gives certain pertinent information. In the Miami area alone, approximately 500 new cases were discovered. The majority of the cases were latent syphilis. Congenital

syphilis was fairly frequent but only a few cases of primary and secondary syphilis were discovered. Over 50 per cent of the entire group had been adequately treated.

The number of reported cases of syphilis during 1954 has remained about the same as the previous year if the new cases resulting from the mass blood testing survey are not included in the total. It is significant to note that there continues to be a decrease in the number of primary and secondary syphilis as compared to latent syphilis in 1954. If this trend continues, one should expect a decrease in the incidence of syphilis during the coming years.

The gonorrhea rate in 1954 was somewhat less than last year. Not much progress has been made in the control of this disease, but different treatment schedules are being tried by the Board of Health on the infected females in an effort to better control this disease.

The treponemal pallidum immobilization test is now available through the State Board of Health, and can be requested on any case in which the physician suspects a biologic false positive reaction for syphilis. However the physician must submit a thorough history of the case, complete physicial examination including spinal fluid studies, and two or more positive or doubtful standard reagin tests before requesting the test. Since the T.P.I. test is the most reliable test to differentiate true from biologic false positive serologic reactions for syphilis, the physician should request this test in all suspected cases.

Respectfully submitted.
A. Buist Litterer, *Chairman*

Dr. Quillian: "The report of the Committee on Tuberculosis and Public Health, presented by Dr. John G. Chesney, is approved as read by Dr. Samuel M. Day.

"I move the report be adopted."

Motion seconded and carried.

Report of Committee on Tuberculosis and Public Health

John G. Chesney, *Chairman*

No major problems necessitating a formal meeting of this Committee have been presented for action this year.

It has been gratifying, however, to see the continued improvement in patient facilities and out-patient services for care and control of tuberculosis in our state.

The proposed joint program of the Florida Heart Association, The National Children's Cardiac Hospital at Miami and the Florida State Board of Health for registration of cases of rheumatic fever was approved.

It is felt that the state, and particularly the local medical association might take closer note of the growing number and size of charity drives directed at specific disease problems. Silence by the medical profession concerning these drives is tantamount to official approval in the eyes of the public, whereas approval should only follow some examination of these drives as to their claims, methods, and accomplishments.

Respectfully submitted,
John G. Chesney, *Chairman*

Dr. Quillian: "The report of the Committee on Medical Postgraduate Course, presented by Dr. Turner Z. Cason, is approved with the following supplemental report, which received full discussion by the reference committee in the presence of the Chairman of the Committee on Medical Postgraduate Course.

"I move the report be adopted as supplemented."

Seconded by Dr. Franz H. Stewart.

Motion carried.

Report of Committee on Medical Postgraduate Course

Turner Z. Cason, *Chairman*

The Medical Postgraduate Course Committee met twice during the year 1954. A summary of the meeting of February 7 was submitted in the 1953 report.

The second meeting of the Committee was held on Nov. 21, 1954. The Twenty-Second Annual Graduate Short Course for doctors of medicine, presented in Jacksonville July 12-16, 1954, was reviewed at length. The total registration of 170 was average. Due to the fact that a large percentage of those in attendance did not stay for the last two days on surgery and the small number in attendance, the Committee considered the question of instituting changes in the presentation of this course. Following the recommendation of a previous meeting, the Chairman had mailed questionnaires to all physicians in the state in which their opinions regarding the Short Course and graduate medical education were solicited. The replies, while not complete, were analyzed at this meeting since the Committee felt they constituted a good cross section, coming as they did predominately from men in every section of the state who had attended previous courses.

A summary of the findings of the 160 replies to this questionnaire is as follows: Question number 1 asked, "Do you desire to have the annual Short Course for doctors of medicine, which will be held again the last week in June of 1955, continued after that time?" Of those replying, 91.1 per cent wished to continue the course while 8.9 per cent voted to discontinue it. Question 1A, the percentage desiring material changes was 16.9 per cent while 83.1 per cent wished no change. Question 1B, with regard to placing obstetrics back on the program of the Short Course, 51 per cent requested that obstetrics remain a part of the program, and 49 per cent requested that it be omitted. The Committee had previously recommended that obstetrics be omitted from the 1954 program in view of the excellent course in obstetrics presented in Daytona Beach the last few years, and it was again recommended that this subject be left out of the 1955 course.

In studying the evenly divided opinions expressed in the questionnaire the Committee expressed the feeling that in the future the Committee should be governed by the wishes of the physicians as expressed in the questionnaire. After discussion of the remaining parts of the questionnaire, the Committee recommended that more panel discussions and question and answer periods be included in future courses.

The revision of the Faculty for the Department of Medicine of the Graduate School of the University of Florida was reviewed. It was decided to continue this revision longer than had at first been anticipated inasmuch as the College of Medicine of the University of Florida has indicated that it anticipates using some of the members of this Faculty for clinical teaching in the undergraduate medical school.

The Committee approved the following courses to be presented by the Florida Medical Association, the Florida State Board of Health, and the Department of Medicine of the Graduate School of the University of Florida: A Seminar on Cardiovascular Diseases will be presented on February 17-18 at the Duval Medical Center in Jacksonville. This seminar is to be sponsored by the Duval District Heart Association and endorsed by the Florida Heart Association. Dr. George T. Harrell Jr., Professor of Medicine and Dean of the College of Medicine of the University of Florida, and three out-of-state speakers will present the program which will include a clinicopathological conference, a clinical conference, panel discussions as well as didactic lectures.

On June 16-18 there will be a course on Psychiatry for the Non-Specialist at the George Washington Hotel in Jacksonville. This course was suggested by the Committee at the fall meeting and approved by all present. The Chairman was authorized to cooperate with the various mental health agencies in presenting this program. Two

night panels are planned to which the public, especially nurses, social workers and law enforcement officers, will be invited. The Twenty-Third Annual Graduate Short Course will also be given at the George Washington Hotel in Jacksonville on June 20-24, inclusive. The first three days will be devoted to medicine, pediatrics, and roentgenology; the last two days to gynecology and surgery.

The Committee came to the decision after much discussion and review of the opinions expressed in the questionnaire that continued emphasis will be placed on the needs of the general practitioner. It further recommended that in the future brief resumes of each subject be included in the program. The Committee also recommended that when the county medical societies are notified of the Short Course that they be urged to publicize it and send two representatives from each society to attend the course. The Committee again approved one day seminars to be presented by the Faculty of the Department of Medicine as requested by individual medical societies.

A course in Diabetes Mellitus was presented in connection with the second annual meeting of the Florida Clinical Diabetes Association in Orlando on Oct. 21-22, 1954. Dr. Joseph T. Beardwood Jr. of Philadelphia, and Dr. H. B. Mulholland of the University of Virginia School of Medicine, were the out-of-state speakers for this meeting. Total attendance was 35. The Florida Clinical Diabetes Association and the Medical Postgraduate Course Committee requested that the Academy of General Practitioners of Florida be contacted to arrange if possible for the 1955 meeting of the Association as well as the graduate seminar on diabetes to be held just prior or immediately after the next annual meeting of the Academy in Daytona Beach.

On November 18-20, 1954 a course on Hematology was held in Jacksonville with Dr. William Dameshek of Boston presenting the program with the assistance of his associate, Dr. Z. D. Komninos of Boston, Dr. James N. Patterson of Tampa, and Dr. John B. Ross of Jacksonville. Total attendance was 71.

The Ninth Annual Ophthalmology and Otolaryngology Seminar was held in Miami Beach on Jan. 17-22, 1955, with 222 physicians in attendance.

Supplement

The Committee on Medical Postgraduate Course recommends to the Florida Medical Association that its function be expanded as follows: That it may invite all interested groups within the State of Florida who are planning formal graduate education courses to submit the proposed program of such activity at a reasonably advanced date to the Committee on Medical Postgraduate Course of the Florida Medical Association for the purpose of coordination and integration of graduate medical activities throughout the state.

Respectfully submitted,
Turner Z. Cason, *Chairman*

Dr. Quillian: "The report of the Committee on Child Health, presented by Dr. Warren W. Quillian, is approved as published in the Handbook. The resolution by the Committee on Child Health concerning the alarming incidence of accidental poisoning from kerosene, and approval of efforts to combat these hazards, was discussed in detail and approved as read to the House of Delegates.

"I move the resolution be adopted as a supplemental report and the report be adopted as supplemented."

Seconded by Dr. Ralph Herz.

Motion carried.

Report of Committee on Child Health

Warren W. Quillian, *Chairman*

Activities of the Committee on Child Health during the past year have been closely coordinated with other existing agencies. We are pleased to find a definite trend toward the use of our personnel in an advisory capacity for the practical solution of problems in child welfare that are frequently encountered by other groups. Since there is no fund provided for a state-wide organized effort, formal meetings of the Committee are not possible, except when emergency circumstances require this at the expense of the individual members.

The Florida Chapter of the American Academy of Pediatrics and the Florida Pediatric Society are now working through sub-committees which include the members of the Child Health Committee in an effort to reduce neonatal mortality and to study accident prevention in childhood. Our Committee has provided lecturers for seminars in collaboration with the Committee on Maternal Welfare, under the able leadership of Dr. E. Frank McCall, Chairman. Programs have been arranged with local organizations, such as Parent-Teacher Associations and Boy Scout groups, to emphasize the need for constant vigilance in our efforts to combat the climbing incidence of accidental injury and death among children. Included among the agencies with which your Committee has worked actively and directly through the year are the Bureau of Maternal and Child Health of the Florida State Board of Health, the Florida Pediatric Society, the Florida Children's Commission and the Cerebral Palsy Association. All of these organizations have instituted programs designed for the betterment of child health in the state.

Our long range plans include efforts to encourage widespread use of facilities for accurate diagnosis and follow-up care among children with congenital heart lesions. Mental health problems need our increasing attention. The organizations primarily concerned with programs devoted to these problems are asking our help and medical guidance. The Committee is eager to furnish assistance as individuals or as a group in any worthwhile enterprise for the betterment of child health in Florida. This type of activity by the Committee will eliminate a great deal of duplicated effort, which would be inevitable if we should undertake a completely independent program.

Resolution

WHEREAS, a recent survey, representing material from approximately two-thirds of the hospitals of this state, indicates that during the year 1953-1954 there have been almost five hundred treated cases of poisoning which resulted from the accidental ingestion of kerosene with five fatalities; and

WHEREAS, it seems reasonable to assume that this hazard (particularly for children) can be reduced by proper identification of small containers of this product, which are sold commercially,

THEREFORE, BE IT RESOLVED, that the Florida Medical Association endorses and commends efforts of the Florida Children's Commission and the Florida State Board of Health to obtain necessary and proper legislation which would make action mandatory.

Respectfully submitted,
Warren W. Quillian, *Chairman*

Dr. Quillian: "The report of the temporary Committee on Mental Health as read to the House of Delegates by Dr. Sullivan G. Bedell, is approved in principle, as amended, with the following comments:

"1. We recommend that the Mental Health Committee be made a standing committee.

"2. We endorse in principle the recommendations as outlined in the report of the Committee on Mental Health and as approved by the Florida Society of Neurology and Psychiatry.

"3. We recommend the following amendment: that in item 5 of the recommendations the wording be changed from 'That the Legislative Program of the Florida Association for Mental Health be endorsed by the Florida Medical Association' to 'That the Legislative Program of the Florida Association for Mental Health be endorsed in principle by the Florida Medical Association.'

"This was done because your reference committee felt that at the time at our disposal it would be impossible to evaluate the large program as outlined in the booklet which was distributed this morning. If you are interested, this can be followed up.

"I move the report be adopted as amended."

Seconded by Dr. Samuel G. Hibbs.

Motion carried.

Report of Committee on Mental Health

Sullivan G. Bedell, *Chairman*

This is a temporary committee pending the action of this House of Delegates.

The committee makes the following recommendations:

1. That the Mental Health Committee be made a standing committee.

2. That the aim of the Committee be to direct attention of members of the Association to affairs relating to the field of mental health, and to serve as liaison with other state organizations interested in mental health.

3. That the Florida Medical Association encourage each county medical society to form a mental health committee.

4. That the Florida Medical Association request the Auxiliary to encourage each county auxiliary to form a mental health committee.

5. That the Legislative Program of the Florida Association for Mental Health be endorsed in principle by the Florida Medical Association.

6. That the State Department of Public Instruction be requested to keep the Mental Health Committee informed of the development of the guidance program in the public schools with the offer that the Mental Health Committee would be willing to serve in an advisory capacity in the formulation of such plans.

The Chairman was requested by the Committee to appear before the Board of Governors, or talk with the President, to suggest that the Board of Governors request the Governor of the State of Florida to proceed with the appointment of a Superintendent for the Southeast State Hospital in Broward County, the Superintendent to be a psychiatrist experienced in hospital administration and certified by the American Board of Psychiatry and Neurology. The President suggested that the Chairman write to Governor Collins and this was done. Governor Collins replied that appropriation for this would be requested by the coming legislature.

The following topics are recommended for study and appropriate action if the Mental Health Committee is continued:

1. The establishment of the position of State Commissioner of Mental Health.

2. Practical approaches to the care of senile psychotics.

3. The establishment of the hospital at Arcadia as an independent state hospital.

4. The advisability of making mental retardation a reportable disease and the possible need of changes in the laws relative to commitment of the mentally retarded.

5. Encouragement of each county medical society toward having at least one scientific program each year related to the field of mental health, the Committee to help, when necessary, in providing speakers.

Respectfully submitted,
Sullivan G. Bedell, *Chairman*

Dr. Quillian: "The report of the Committee on Maternal Welfare, presented by Dr. E. Frank McCall, is approved as published in the Handbook. The excellent constructive work accomplished by this Committee under the able leadership of Dr. E. Frank McCall is reflected in the lower incidence of maternal deaths in the state during the past few years.

"I move the report be adopted."

Seconded by Dr. Edwin W. Brown.

Motion carried.

Report of Committee on Maternal Welfare

E. Frank McCall, *Chairman*

We have formed no new Maternal Welfare Committees in the state this year, but those already formed are doing a very excellent job of reviewing the maternal deaths in their communities.

The Maternal Welfare Committee sponsored by the State Boards of Health of Florida, Georgia, and South Carolina, held an Obstetric and Pediatric Seminar at Daytona Beach September 13-15. This meeting was better attended than any of the previous years. Total registration was 283. The faculty for this meeting was as follows:

Dr. Allan C. Barnes, Western Reserve University;
Dr. Willis E. Brown, University of Arkansas;
Dr. Fred L. Adair, Maitland, Fla.;
Dr. F. Bayard Carter, Duke University;
Dr. Stewart H. Clifford, Children's Hospital, Boston, Mass.;
Dr. W. E. Kittredge, Tulane University School of Medicine;
Dr. Milton L. McCall, Louisiana State University;
Dr. William F. Mengert, Southwestern Medical School, Univ. of Texas;
Dr. Warren W. Quillian, Jackson Memorial Hospital, Miami;
Dr. Robert A. Ross, University of North Carolina.

For this meeting we were able to obtain thirteen exhibitors. The majority of the cost of the meeting was provided for by the Florida State Board of Health (Bureau of Maternal and Child Health).

Plans have been completed to continue this meeting in Daytona Beach in September 1955 and a very representative group of outstanding professors has been obtained for this meeting.

It is with pleasure that we report only sixty maternal deaths in Florida for the year 1954. This gives us a maternal mortality of 0.6 per 1,000 for the state, which is the lowest in the history of the state. Florida again will rank among the top states in the nation, and we would like to give due credit to all the Florida physicians who practice Obstetrics. We can all be proud of their ability and desire to keep up with modern medicine and by so

doing keep our mortality at the national average and below.

I would like to express our sincere thanks to the State Board of Health for making our Obstetric Seminar possible. They have always been most helpful in any worthwhile venture.

We would like to thank our President, Dr. Duncan T. McEwan, for his cooperation during this year and again thank him for taking time out from a very busy schedule to be with us in Daytona Beach for the Seminar.

Respectfully submitted,
E. Frank McCall, *Chairman*

Report of Reference Committee No. 2

The Chair called for the report of Reference Committe No. 2, Public Policy, by Dr. Edward Jelks, Chairman.

Dr. Jelks: "Reference Committee No. 2 met yesterday afternoon. Present were Drs. H. Phillip Hampton, Robert F. Dickey, Francis H. Langley, William C. Roberts and your chairman. In the deliberations of this committee, we had the advantage of the presence of someone who is especially interested in each one of these reports and resolutions and we hope we have reached conclusions which will meet with your approval.

"The report of the Committee on Conservation of Vision, presented by Dr. G. Tayloe Gwathmey, is approved as submitted.

"I move the report be adopted."

Seconded by Dr. Carl S. McLemore.

Motion carried.

Report of Committee on Conservation of Vision

G. Tayloe Gwathmey, *Chairman*

(1) It is the view of the present Committee that it would be premature to advocate a screening for glaucoma in the State of Florida at this time. The early diagnosis of glaucoma is of really great value in the narrow angle type with physiological pupillary block, and it is precisely in this type of case that a single tonometric reading will not only fail to disclose the condition but will give a false sense of security which may lead these patients to not seek an ophthalmologist until the invaluable opportunity for cure with peripheral iridectomy is lost. A program directed toward encouraging older people to seek medical examination of their eyes, and the continuation of the effort to make the public glaucoma conscious without excessive dread of the disease are recommended. Awareness by ophthalmologists of the need for very early diagnosis of the narrow angle glaucoma with physiological pupillary block is also recommended.

(2) This Committee also recommends that the profession as a whole advocate the properly illuminated Snellen Test Chart as the most practical method of vision screening of school children. Muscle balance testing, with or without machines, has not proven satisfactory. Excessive time is consumed, which means inefficient employment of personnel. Also there is too high a percentage of over-referrals when the machines are used for muscle testing. The use of a 2.50 diopter fogging test in third grade school children is considered desirable if circumstances permit.

Respectfully submitted,
G. Tayloe Gwathmey, *Chairman*

Dr. Jelks: "The report of the Committee on Legislation and Public Policy, presented by Dr. H. Phillip Hampton, represents an unusual amount of work. This report was discussed thoroughly and we approve it as presented.

"I move it be approved by this body."

Seconded by Dr. Franklin J. Evans.

Motion carried.

Report of Committee on Legislation and Public Policy

H. Phillip Hampton, *Chairman*

The primary activities of your Committee have been the planning and preparation for the 1955 Session of the Florida State Legislature.

Your Committee studied all the proposed legislation received from the county medical societies, referred by the Association's President, requested by the House of Delegates, referred by allied organizations and state officials.

This proposed legislation was presented with recommendations to the Pre-Legislative Joint Meeting of the FMA Board of Governors, members of the House of Delegates, Bureau of Public Relations and Committee on Legislation and Public Policy held on Nov. 29, 1954, in Miami. The proposed legislation was discussed at this meeting and a definite program was adopted.

The more important proposed bills were sent to the chairman of the legislative committee and a copy to the president and secretary of each county medical society, urging them to inform the county medical society members, explain them to their Senator and Representatives prior to the 1955 Session of the Legislature, and inform us of the individual legislator's reaction to each bill.

Many meetings and conferences have been held, personal contacts made, communications written and numerous other activities which would be too voluminous to include in this report. Special note should be made that the President of the Senate and the Speaker of the House have been contacted by representatives of the Association urging them to appoint legislators to the Public Health Committee of the Senate and the House who will assure that fair consideration is given to the Association's legislation in hearings before these committees. When the chairman of the House Public Health Committee was appointed, a member of your Committee immediately contacted him and discussed our Legislative Program.

An office will be maintained at Tallahassee during the entire 1955 Session of the Legislature by Harold Parham, of the Association's executive office, and an attorney retained by the Association. This office is for the convenience of the legislators and others who may seek information on problems concerning medicine, health and education as they effect legislation for the protection and benefit of Florida's citizens.

Again your Committee would like to emphasize that the success or failure of our Association's state legislative program depends primarily upon work done at the local level by an informed membership in developing better relations with legislators at home prior to the legislative session.

Your Committee has cooperated in every way possible on national legislation, during the past year, with the American Medical Association's Committee on Legislation and the Washington Office.

Today's Health, the American Medical Association's health magazine for lay readers, is being sent again this year to Florida's U. S. senators and representatives, the Governor and members of his Cabinet and state legislators.

On behalf of the Committee, I desire to express appreciation for the assistance rendered by the President, Secretary, and other state association officers, Supervisor of the Association's Bureau of Public Relations, and other members of the executive staff, members of the legislative committees of the county medical societies and the many individual members who have responded when called on for assistance.

Respectfully submitted,
H. Phillip Hampton, *Chairman*

Dr. Jelks: "The report of the Committee on Medical Education and Hospitals, presented by Dr. Jack Q. Cleveland, is approved as submitted.

"I move the report be adopted."

Seconded by Dr. Ralph Herz.

Motion carried.

Report of Committee on Medical Education and Hospitals

Jack Q. Cleveland, *Chairman*

Your Committee Chairman attended the annual meeting of the State Chairmen of the American Medical Education Foundation. This meeting was held in Chicago on January 23, 1955, and it is, annually, the kick-off for the year's fund raising activity for the Foundation.

In 1954, in Florida, fifty-four doctors contributed $3,184 to the Foundation which meant that Florida was thirty-second of the forty-eight states in amount of money contributed. This seems a relatively small amount and very few men to contribute to this Foundation. This amounts to less than one dollar apiece for all the doctors in the state. Your Committee would like to strongly urge that each member of the Florida Medical Association contribute *at least* five dollars apiece to the Medical Education Foundation in 1955. We are aware that the fifty-four contributors in 1954 gave more than $5 apiece, but if each man would contribute a minimum of $5, we feel that Florida Medical would be doing its share. The Foundation raised $1,182,627 in 1954, and all of this amount was distributed to the eighty medical schools in the U.S. Not one cent was used for administrative costs. This cost is borne by the American Medical Association.

Today at least $5,000,000 is needed to meet urgent medical school needs; another $5,000,000, to overcome equally pressing long range problems. Lack of funds is endangering the nation's medical standards. Gifts, income from endowments, general university funds and public appropriations no longer provide sufficient revenue to meet current operating costs, let alone future demands. Funds from other sources must be found before irreparable harm is done. These funds must come either from government or private sources. The latter is certainly preferable.

Today, the medical profession is making immeasurable contributions to the betterment of impoverished populations the world over. A medical educational system free from government control is essential if these contributions are to continue and improve.

Respectfully submitted,
Jack Q. Cleveland, *Chairman*

Dr. Jelks: "The report of the Committee on Medical Economics, presented by Dr. Robert E. Zellner, is approved in its entirety, including the supplement on the Insurance Plan. Also approved was the motion that the committee chairman and the committee be commended for their good work.

"I move the report be adopted as supplemented."

Seconded by Dr. Chas. W. Bartlett.

Motion carried.

Report of Committee on Medical Economics

Robert E. Zellner, *Chairman*

The Medical Economics Committee has held one meeting in Jacksonville in the past year and has had voluminous correspondence with the Association office and with members of the Committee on the matters assigned to the Committee.

The Board of Governors referred to the Committee for study a resolution presented by the Pinellas County Medical Society at the last annual meeting of the House of Delegates requesting the American Medical Association to establish a Council on Insurance. A letter was written to Dr. Percy Hopkins, Chairman of the Committee of Prepayment Insurance of the American Medical Association, advising him of the resolution and asking for information concerning the activities of the American Medical Association in the approval of hospitalization and health insurance policies. A letter was received from the American Medical Association stating that efforts on a national level to investigate individual insurance policies had not been very successful and that it was the feeling of the American Medical Association at the present time that such evaluation could best be done on a local level. It was also indicated that in many states the associations of health and accident underwriters along with the state insurance commissioners are attempting to police their own ranks, which seems more desirable than for medical organizations to attempt to do it for them.

Recommendation

It is recommended that the Florida Medical Association cooperate with the Florida Association of Health and Accident Underwriters and with the State Insurance Commissioner in improving the quality of health and accident insurance policies available in this state and that the Florida Medical Association not undertake any independent action of its own in the field of insurance policy approval at the present time.

A resolution presented by the Indian River County Medical Society at the last annual meeting of the House of Delegates recommending a revision of the fee schedule and income limits as prescribed in Blue Shield contracts was referred for study to this Committee. This resolution was brought to the attention of Mr. H. A. Schroder, Executive Secretary, and Dr. David R. Murphey Jr., President of Blue Shield of Florida. The Committee was informed that Blue Shield was aware of certain inequities in its fee schedule, that this matter is being studied at the present time, and that changes would be made in the schedule from time to time provided that they were actuarily sound.

Recommendation

The Florida Medical Association urges its members to become participating members of Blue Shield of Florida, to attend its meetings, and to take part in its organization through their delegates, thus insuring that its fee schedule and its other activities represent the consensus of the physicians of Florida.

The Board of Governors referred to the Committee for its recommendation a matter in which an Association member treated an injured workman insured under the Workmen's Compensation Act, collected from the underwriter the fee allowed in the Fee Schedule, and then charged and collected an additional fee from the injured workman. A review of this case had been requested by the Director of the Florida Industrial Commission.

Recommendation to the Board of Governors

The Committee agrees that a physician is undoubtedly within his rights to set his own fees, but it feels that it is morally wrong and not in the best interests of the Association for one of its members to accept fees from patients covered by Workmen's Compensation when those

fees are supposed to be paid by the insurance underwriter. The Committee further recommends that this matter be referred back to the appropriate county medical society for further consideration and that the Florida Medical Association notify the Insurance Commissioner of its intention to urge its members to abide by the fee schedule in the future.

The project of greatest magnitude assigned to this Committee this year has been the investigation of the professional liability insurance problem. This has entailed the collection of information from the Medical Societies of the other forty-seven states; correspondence with the Florida Insurance Commissioner, the National Board of Casualty Underwriters, and numerous insurance companies; the study and analysis of the collected data and information; and the application of our conclusions to the solution of our own problems. The work of this Committee this year has been made possible because of the prodigious work of the Association Secretary, Dr. Samuel M. Day, who for the past several years has been studying the professional liability insurance problems. His insight into this type of insurance, his great fund of information on this subject, and his readiness to lend his assistance at all times have been of invaluable help.

After analyzing the experience of other medical associations the Committee proposed a plan for group professional liability insurance for the members of the Florida Medical Association. This was presented to the Board of Governors, which approved this plan and authorized the Committee to begin negotiations with interested insurance companies. The details of this plan have been publicized in The Journal of the Florida Medical Association. In its investigation the Committee has learned several things which are of general interest and should be understood by every member of the Association:

1. Most malpractice suits are *caused* by the physician himself or by an unnecessarily critical fellow physician.

2. The rise in professional liability insurance rates of the past few years has been *justified by increased loss experience* of the insurance companies.

3. Insurance companies are becoming less and less interested in writing professional liability insurance *at any rates.*

4. The only way in which the trend toward ever rising rates for professional liability insurance can be reversed is for the individual physician, the county medical societies and the State Association to take an active interest in this matter. In this opinion the Florida Insurance Commissioner concurs and he has indicated that his attitude toward the granting of further rate increases will be influenced in part by what the Association itself does to help minimize the loss ratio.

5. No reliable statistics on losses incurred in Florida from professional liability insurance now exists. The insurance companies themselves have had no standard system of accounting nor have they pooled their statistics. There is no record of the losses sustained in out-of-court settlements or from legal fees incurred in claims in which no settlement was made. With these facts in mind the Committee makes certain recommendations:

Recommendation I

The Association continue its efforts to acquire a satisfactory group professional liability insurance policy with a major insurance company whose financial soundness is unquestioned.

Recommendation II

The Florida Medical Association conduct a continuing program through its annual meetings, the district meetings, the county medical societies, and its various publications to educate its members in matters related to the causes and prevention of suits for malpractice.

Recommendation III

The Association begin to collect its own statistics of the losses incurred in Florida from malpractice suits and threats of suits.

Recommendation IV

The Association recommend that the by-laws of each county medical society be amended to the effect that it will be mandatory that each member of the society report to the society immediately any threat of malpractice suit. The society should collect all pertinent data in the case and notify the Association office immediately. When the case is concluded the total amount of money expended for fees, court costs, damages, etc. should be ascertained and recorded at the Association office.

Recommendation V

Each county medical society organize an insurance committee for the purpose of assisting the insurance underwriter in ascertaining the facts in all threats of suits for malpractice against its members and in advising the threatened physician and the underwriter as to the proper disposition of the case.

Recommendation VI

Each county society take action through the Board of Censors, or other appropriate committee, against any of its members whose actions have been responsible for unwarranted exposure of another physician to the charge of malpractice.

The Committee feels that this is only a small start toward the solution of a very grave problem and that the success of our efforts will be in proportion to the unity of our efforts. This cannot be accomplished unless the physicians of Florida sacrifice a little bit of individuality and work together toward a common goal for the common good.

In conclusion, the Chairman wishes to thank the individual members of the Committee for their interest, their help, and their advice in the matters which have been under consideration by the Committee during the past year.

Supplement

The Medical Economics Committee held its second meeting on February 20, 1955, at the George Washington Hotel in Jacksonville. The previous day the Chairman and Mr. Ernest Gibson had spent with Mr. Harry F. Wanvig, Indemnity Representative of the Medical Society of the State of New York. Because of his vast knowledge in the field of professional liability insurance, Mr. Wanvig had been asked by the Committee to meet with it to assist in developing a plan more attractive to insurance companies and to advise the Committee in finding a company which would be interested in underwriting a group malpractice contract in accordance with the plan. Mr. Wanvig, Mr. Gibson and the Chairman interviewed several insurance men regarding professional liability insurance as well as group disability insurance. At the meeting of the Committee insurance representatives again presented their ideas. The Committee decided, upon the advice of Mr. Wanvig, to recommend to the Board of Governors that Marsh and McClennan, insurance brokers of New York, be appointed the exclusive representatives of the Association for a period of time for the purpose of finding an insurance company which would sign a contract with the Association for a group malpractice insurance policy in accordance with the plan approved by the Board of Governors. This recommendation was presented to the Board of Governors at its meeting a week later and was approved.

The Committee felt that since it was to the Association's advantage to obtain the best possible contract it should not act in haste and should not consumate the contract without careful consideration and deliberation. It has not been possible to do this prior to the Annual Meeting of the House of Delegates. Since it will also be to the Association's advantage to commit itself to a contract once a satisfactory agreement has been made, it was the Committee's recommendation that the Board of Governors should be empowered to act for the Association in the interim between annual meetings. This recommendation was presented to the Board of Governors at its February 27 meeting and was approved.

Recommendation

That the House of Delegates authorize the Board of Governors upon recommendation of the Medical Economics Committee to act for the Association in contracting with an insurance company to provide a group professional liability insurance plan to be made available to members of the Association.

Respectfully submitted,
Robert E. Zellner, *Chairman*

Dr. Jelks: "The report of the Committee on State Controlled Medical Institutions, presented by Dr. Samuel G. Hibbs, is approved as submitted.

"I move the report be adopted."

Seconded by Dr. Hollis F. Garrard.

Motion carried.

Report of Committee on State Controlled Medical Institutions

Samuel G. Hibbs, *Chairman*

I wish to report on the Florida State Hospital at Chattahoochee, the Florida State Hospital at Arcadia, the Florida Farm Colony at Gainesville, and the progress up to date on the new state hospital in Broward County.

The State Hospital at Chattahoochee continues to grow; they have added a 250 bed active-treatment building, 100 additional beds for patients suffering from tuberculosis, and 600 beds for old people. The staff at Chattahoochee has also been increased, which is commendable.

At the Arcadia branch an increase in bed capacity is being made by the addition of new buildings up to approximately 660 beds. There are at present two psychiatrists at Arcadia to care for about 1,200 patients. There is still a definite need for more psychiatrists at Arcadia; and a more extensive occupational therapy program headed by a trained occupational therapist, particularly for the men, is needed. It is believed that a much more active farm program could be utilized by both males and females at the Arcadia Branch than exists at the present time.

The Florida Farm Colony at Gainesville is continuing the very progressive program, not only in additional physical facilities, but in their staff. In 1954, they saw Negro mentally retarded and epileptic children admitted for the first time in quite adequate facilities. They are continuing to enlarge their academic school program. They now have two full time physicians who are doing an excellent job in caring for the many medical problems that arise, and who are also interested in research on both the mentally retarded and epileptic patients. They also have added a full time psychologist this past year who should be very helpful in classifying the various patients, which has not been adequately done in the past.

Construction on the new South Florida State Psychiatric Hospital in Broward County has not as yet been started, but the contract was let Feb. 1, 1955, and construction should begin in the very near future. It is felt that a medical director, who has not only administrative ability but who is also a trained qualified psychiatrist, should be employed immediately so that he can become thoroughly familiar with the plans and be able to advise as needed.

I would like to repeat again this year that I feel that we, as doctors of medicine, can point with reasonable pride to our state controlled medical institutions and feel that the following recommendations would be in the further interest of these institutions:

1) that no new construction which will increase the patient population at the Florida State Hospital at Chattahoochee be approved;

2) that state appointed consultants who are Certified in Psychiatry and Neurology attend a certain number of the staff meetings each year at the various State hospitals for the purpose of stimulating the men on these various staffs. (Both the Veterans Administration and the Armed Services utilize private practicing physicians as consultants and find that this works very satisfactorily not only in helping the staff doctors with the more difficult cases, but as a stimulating force for their interest in medicine);

3) that additional psychiatrists and other professional aids be obtained for the Arcadia branch of the Florida State Hospital.

Respectfully submitted,
Samuel G. Hibbs, *Chairman*

Dr. Jelks: "There was no report from the Committee on Representatives to Industrial Council. We pass this on as information.

"The report of the Grievance Committee, presented by Dr. Walter C. Payne Sr., is approved as submitted.

"I move its adoption."

Seconded by Dr. Herbert L. Bryans.

Motion carried.

Report of Grievance Committee

Walter C. Payne Sr., *Chairman*

It is unfortunate that every member of our Association cannot serve at least one year as a member of our State Grievance Committee. One cannot serve in that capacity and not be impressed with the need of such a committee and with the opportunity it offers to improve our public relations.

The temporary success that has been achieved in halting the trend toward socialized medicine has lulled too many of our members into a false sense of security. There is an all too prevalent opinion that this movement has been defeated and is a dead issue. Last year one of our county medical societies passed a resolution to the effect that since the issue of socialized medicine has been defeated, there is no longer a need for our Public Relations Bureau and that it should be abolished, and our dues reduced. As a matter of fact, far from being a dead issue, it has never been more alive than today. We have passed through only the first phase in this fight. If there was ever a time when all of our members need to conduct themselves in a manner to deserve the good will of the public it is now.

Your State Committee would again this year like to emphasize the all important role the county grievance committees play. As a matter of fact, without the cooperation of the county committees, the State Committee cannot function. There has been an improvement in the attitude of the county committees and some of them are doing outstanding jobs. In many instances, however, there is need for more understanding and cooperation.

Last year your Committee reported that there had been a diminution in the number of complaints received. It regrets that it cannot make such a report this year. More complaints have been received than in any other year except the first year of operation. It is also our embarrassing duty to tell you that some of the complaints are justified.

It might be well to call attention again to a persistent cause of complaint. We refer to the problem of a surgical assistant's fee as an outstanding cause for complaint. Misunderstandings arising from this problem could so easily be avoided. If the surgical assistant is to render a separate bill from that of the surgeon, then the patient should be so informed by the surgeon. This information should be given prior to the operation. It is obvious that when a patient pays his surgeon and later receives a statement from an assistant, whom he did not know had assisted and who is perhaps unknown to him personally, he has a just cause for complaint.

This being the Chairman's last year as a member of the Grievance Committee, he would like to take this opportunity to express appreciation for the innumerable

courtesies shown him. He would also like to express the hope and belief that the incoming Chairman will receive full cooperation from the county grievance committees and from all our members.

Respectfully submitted,
Walter C. Payne Sr., *Chairman*

Dr. Jelks: "The report of the Judicial Committee of the Florida Society of Anesthesiologists, presented by Dr. Adelbert F. Schirmer, Chairman, is approved as an instrument of information and for information purposes only with no action to be taken."

Report of the Judicial Committee of the Florida Society of Anesthesiologists

Adelbert F. Schirmer, *Chairman*

WHEREAS, the Florida Society of Anesthesiologists had requested of the Attorney General of the State of Florida through the agency of the Florida State Board of Medical Examiners his opinion as to the legality of hospitals hiring physicians and selling their services at a profit to the hospital

WHEREAS, the Attorney General of the State of Florida on March 25, 1955, gave his opinion that this was the practice of medicine by corporations and as such was illegal

BE IT THEREFORE RESOLVED THAT this resolution be the official notification of such opinion of the Attorney General of the State of Florida to the House of Delegates of the Florida Medical Assoication

AND BE IT FURTHER RESOLVED THAT this decision of the Attorney General of the State of Florida be submitted to the Florida Medical Association as an instrument of information and for information purposes only with no action to be taken.

Respectfully submitted,
Adelbert F. Schirmer, *Chairman*

Dr. Jelks: "Next is a resolution submitted by Dr. Adelbert F. Schirmer as an individual, commending Governor Collins for his action in the study of the problem of indigent care with recommendations to the Legislature for the solution of these problems.

"Your committee has amended this resolution slightly, and I recommend its adoption as amended.

"I move the resolution be adopted as amended."

Seconded by Dr. Achille A. Monaco.

Motion carried.

Resolution

RESOLVED that the Florida Medical Association commend Governor Collins for his study of the problem of indigent hospitalization in Florida and that the Florida Legislature of 1955 be urged to enact the recommendations of the report of the Committee on Indigent Hospitalization into law.

AND BE IT FURTHER RESOLVED that copies of this Resolution be forwarded immediately to the Governor and the appropriate members of the Legislature.

Respectfully submitted,
Adelbert F. Schirmer

Dr. Jelks: "The resolution introduced by the Broward County Medical Association referring to medical care by the doctors of the State of Florida for members of our state governing bodies has been withdrawn by the delegates from Broward County."

Dr. Jelks: "The resolution presented by Dr. James L. Borland of Duval requesting a study of pre-payment health insurance is not approved because this subject is covered by a report of the Committee on Medical Economics.

"I move the resolution be disapproved and not published in The Journal."

Seconded by Dr. Hibbs.

Motion carried.

Dr. Jelks: "The resolution presented by the Orange County Medical Society on the Physical Therapist Practice Act is not approved. Acceptance is opposed as the resolution is not specific and will not give the Legislative Committee of the F.M.A. freedom of action to protect the interest of patients.

"I move the report be disapproved and not published in The Journal."

Motion seconded and carried.

Report of Reference Committee No. 3

Dr. John D. Milton, Chairman of Reference Committee No. 3, Finance and Administration, was recognized and asked to present the report of that committee.

Dr. Milton: "Reference Committee No. 3 met with the entire committee present, Drs. Samuel M. Day, Francis T. Holland, Edward R. Annis, W. Dean Steward, and your chairman.

"The report of the Committee on Advisory to Woman's Auxiliary, presented by Dr. Wiley M. Sams, is approved as submitted.

"I move the report be adopted."

Seconded by Dr. Herschel G. Cole.

Motion carried.

Report of Committee on Advisory to Woman's Auxiliary

Wiley M. Sams, *Chairman*

A detailed report of the work of the Woman's Auxiliary will be submitted by that organization at a later date, when their year is terminated on May 31, 1955. The work which has been carried on, and the projects which they have accepted and promoted are such as to be a credit to organized medicine. Under the able leadership of their current President, Mrs. Richard F. Stover, the duties of an Advisory Committee have indeed been light.

New projects during the past year include support of the Duval Brewster School of Nursing, additions to the school library, an exhibit on Nurse Recruitment and Today's Health magazine at the Florida State Fair, support of the Future Nurses Clubs which are sponsored by the State Auxiliary, and assistance in an educational campaign on Health Insurance.

Continued activities include support of Public Relations, Student Loan Fund, American Medical Education Foundation, "Today's Health," Nurse Recruitment, Civil Defense, Mental Health, Doctor's Day and the Jane Todd Crawford Loan Fund. There have been no changes in

the policy of operation or the program of the Auxiliary organization, and the Advisory Committee has been informed concerning new projects which have been adopted.

Respectfully submitted,
Wiley M. Sams, *Chairman*

Dr. Milton: "The report of the Committee on Councilor Districts and Council, presented by Dr. Francis H. Langley, is approved as submitted.

"I move the report be adopted."

Seconded by Dr. Walter W. Sackett Jr.

Motion carried.

Report of Council

Francis H. Langley, *Chairman*

The Council met in Hollywood during the meeting of the Florida Medical Association. It was decided to have the District Meetings in October, and these were held in Marianna, October 11; Sanford, October 13; Vero Beach, October 14; and Sarasota, October 15. The scientific programs were held as forums, and I believe that the members attending were well pleased with this procedure. The state officers reported on various phases of the activities of the Assoication.

The dinners and social hours were particularly enjoyable. I feel that the committee on arrangements for each meeting is to be highly congratulated, as everything was well planned and the meals were excellent.

Present at the meetings, in addition to the officers, were Dr. Robert B. McIver, Dr. Wilson T. Sowder, Mr. Ernest Gibson and Mr. Harold Parham. Representing the Auxiliary were Mrs. Richard F. Stover, State President, and Mrs. Edward W. Cullipher, State Treasurer. Their presence added greatly to the dinner meetings and they conducted the Auxiliary meetings during the afternoons.

We had hoped the Council might have no functions beyond those mentioned but certain disputes soon came to our attention. These were promptly investigated by the Councilors of the respective districts and careful reports were rendered. A meeting of the Council was held in Miami on Sunday, Nov. 28, 1954. At that time the individuals concerned were heard, in so far as they were present. The Council members questioned them to clear up any points not covered in the reports.

Each case was then taken up and recommendations were made to the Board of Governors, which were submitted with a complete transcript of all reports and correspondence.

I wish to thank the members of Council who have given generously of their time and ability, namely: William P. Hixon, George S. Palmer, Henry J. Babers, Thomas C. Kenaston, Clyde O. Anderson, James R. Boulware Jr., James R. Sory and Russell B. Carson.

Respectfully submitted,
Francis H. Langley, *Chairman*

Dr. Milton: "The report of the Committee on Advisory to Selective Service for Physicians and Allied Specialists, presented by Dr. J. Rocher Chappell, is approved as submitted.

"I move it be adopted."

Seconded by Dr. Cecil M. Peek.

Motion carried.

Report of Committee on Advisory to Selective Service for Physicians and Allied Specialists

J. Rocher Chappell, *Chairman*

This Committee has no activities to report.

Respectfully submitted,
J. Rocher Chappell, *Chairman*

Dr. Milton: "The report of the Committee on Emergency Medical Service, presented by Dr. James V. Freeman, is approved as submitted.

"I move it be adopted."

Seconded by Dr. Melvin M. Simmons.

Motion carried.

Report of Committee on Emergency Medical Service

James V. Freeman, *Chairman*

The Committee has this past year continued in the various activities of emergency medical problems dealing chiefly with the Civil Defense aspect, and planning in the event of any catastrophies, bombing, etc. The over-all plan for the State of Florida has been prepared and is in the hands of the Director of Civil Defense.

There was a meeting in December, 1954, in Atlanta concerned with implementation of the planning for this entire Southeast region with integration of the facilities of the various regions, and this meeting was attended by your Chairman as part of this Committee. There will be a second meeting of this nature in Atlanta in June, 1955.

The State of Florida Civil Defense Office lost its Director in the untimely death of Colonel Howey in July, 1954, but this office has been filled by James E. Keezel.

Respectfully submitted,
James V. Freeman, *Chairman*

Dr. Milton: "The resolution on formation of a standing Committee on Nursing, presented by the Escambia County Medical Society, is approved as submitted, with the recommendation that appropriate By-Law changes be presented to the next House of Delegates.

"I move the resolution be adopted."

Seconded by Dr. Raymond S. Roy.

Motion carried.

Resolution

WHEREAS, The nursing situation is changing rapidly; and

WHEREAS, The supply is inadequate to meet the ever increasing demand and;

WHEREAS, The Doctors of Medicine have been invited to serve on the State and local Professional Advisory Councils for Practical Nurses, and;

WHEREAS, the Professional Nurses Association is frequently requesting consideration and approval of Nursing Legislation, therefore be it

RESOLVED, That the House of Delegates of the Florida Medical Association establish a standing Committee on Nursing, composed of five members; one to be appointed from each of the four medical districts and one at large. The first appointments from the districts shall be for one, two, three, and four years, thereafter the appointments will be for four years. The member from the State at Large shall be for one year only and thereafter for one year.

I certify that this Resolution was adopted by the Escambia County Medical Society at its regular meeting on March 8th, 1955.

Respectfully submitted,
Paul F. Baranco, *Secretary*
Escambia County Medical Society

Dr. Milton: "The resolution on the formation of a State Committee on Blood, presented by the Orange County Medical Society, is approved as submitted, with the recommendation that appropriate By-Law changes be presented to the next House of Delegates.

"I move the resolution be adopted."

Seconded by Dr. Francis T. Holland.

Motion carried.

Resolution

WHEREAS, The American Medical Association Committee on Blood reported the formation and operation of state blood bank committees in many states, and

WHEREAS, The recent formation of the National Blood Foundations demands the cooperation of members of the Florida Medical Association with the American Association of Blood Banks, particularly in deciding the type of blood-collecting program suited for their areas, and

WHEREAS, The Florida Association of Blood Banks and State Civil Defense are desirous of a liaison with the Florida Medical Association, and

WHEREAS, It is felt that the responsibility of supervision of facilities for collection, processing, storage and distribution is resting upon the medical profession,

BE IT RESOLVED THAT, The Florida Medical Association form a State Committee on Blood. Representation on the committee of a member from the Florida Association of Blood Banks and the American Association of Blood Banks would be desirable. The function of the Committee would be largely advisory to the local societies and also to State Delegates to the American Medical Association. The importance of adequate blood collection and distribution in times of emergency cannot be overemphasized.

Note: Reference is made to the report of the A.M.A. Committee dated November 28, 1954.

Respectfully submitted,
W. Ansell Derrick, *Secretary*
Orange County Medical Society

Dr. Milton: "The resolution expressing gratitude for the opportunity of entertaining the AMA Clinical Session, presented by Dr. E. W. Cullipher, is approved as submitted.

"I move its adoption."

Seconded by Dr. Samuel G. Hibbs.

Motion carried.

Resolution

WHEREAS: The Florida Medical Association and its component societies were dignified by the selection of Miami as the site of the 1954 American Medical Association Clinical Meeting by the House of Delegates of A.M.A., and

WHEREAS: The Dade County Medical Association in cooperation with the Florida Medical Association and the American Medical Association, did sponsor and plan a Health Fair for the Public, immediately subsequent to the close of the A.M.A. Clinical Meeting, and

WHEREAS: The members of the Florida Medical Association individually and collectively, have been complimented by various officials of the A.M.A., many individual members of the A.M.A., and the public in general, for the successful conduct of the A.M.A. Clinical Meeting and the Health Fair for the Public.

NOW THEREFORE BE IT RESOLVED: That the Florida Medical Association goes on record as expressing its gratitude for the opportunities afforded it by the very presence of these two major events within its boundaries, and particularly recording its appreciation for the excellent cooperation of all the officials and employees of A.M.A., who helped to make these two projects highly successful.

BE IT FURTHER RESOLVED: That a copy of this resolution be forwarded to the Secretary of the American Medical Association.

Respectfully submitted,
Edward W. Cullipher, *Delegate*
Dade County Medical Association

Dr. Milton: "Now we come to the report of the Board of Governors and we have separated part of this report because we think that the By-Law changes should be taken up individually.

"The By-Law change on the annual meeting of Past Presidents is approved as presented in the Handbook.

"I move it be adopted."

Seconded by Dr. Carl S. McLemore.

Motion carried.

Dr. Milton: "The By-Law change to establish a standing Committee on Mental Health is approved as submitted.

"I move it be adopted."

Motion seconded and carried.

Dr. Milton: "The By-Law change on application for membership is approved with the following amendment: That the phrase 'entitled to apply for membership' shall be changed to 'privileged to apply for membership.'

"We recommend that the Special Committee on Membership Classifications be asked to study this By-Law, giving special consideration to the meaning and intent of the word 'non-sectarian.'

"I move it be adopted as amended."

Seconded by Dr. Eugene G. Peek Jr.

Motion carried.

Dr. Milton: "The recommendation of the Board of Governors that the 1956 Annual Meeting be held at the Hotel Fontainebleau, Miami Beach, is approved as presented.

"I move its adoption."

Seconded by Dr. Carroll V. Herron.

Motion carried.

Dr. Milton: "The report of the Liaison to Board of Governors on Public Relations, as presented by Dr. Edward Jelks, is approved as submitted.

"The report of the Sub-Committee to Board of Governors on Veterans Care, as presented by Dr. Frederick H. Bowen, is approved as submitted.

"The report of the Sub-Committee to Board of Governors on Blue Shield, as presented by Dr. David R. Murphey Jr., is approved with the following amendment: In the last line of this report, at the bottom of page 37 of the Handbook, the words 'in March 1954' shall be inserted between the words 'Governors' and 'recommended,' so that the last clause of this sentence at the bottom of the page shall read: 'and the Board of Governors in March 1954 recommended.'

"The supplemental report of the Board of Governors is approved as presented.

"The report of the Board of Governors, as a whole, with its supplement, is approved as amended.

"I move that this report with its supplement be approved as amended."

Seconded by Dr. Francis T. Holland.

Motion carried.

Report of Board of Governors

Duncan T. McEwan, *Chairman*

Three meetings of the Board of Governors were held as follows: April 28, September 19 and November 30, 1954. An expression of gratitude is due the members of the Board, many of whom travel great distances at their own expense to attend these meetings.

Recommendation—By-Law Change

Annual Meeting of Past Presidents

Your Board recommends:

That Chapter VII, Section 20 of the By-Laws be amended by:

(1) Striking out the entire sentence in line 3 following the word "Board," and substituting therefor "They shall have the privilege of discussing any matter under consideration by the House of Delegates, but they shall not have the power to vote on any question except for those past presidents who have been officially seated as delegates from their respective county medical societies."

(2) Striking out the phrase "the opening day of each" following the word "held" in line 11 and substituting therefor "at each"

(3) Deleting the phrase "after the first session of the House" in line 12 following the word "Convention"

(4) Deleting the remainder of the section following the word "Delegates" in line 16

The amended By-Law to read:

Sec. 20. BOARD OF PAST PRESIDENTS—The General Advisory Board of Past Presidents. All past presidents automatically become members of this Board. They shall have the privilege of discussing any matter under consideration by the House of Delegates, but they shall not have the power to vote on any question except for those past presidents who have been officially seated as delegates from their respective county medical societies. They may be called upon by any committee to act in an advisory capacity and are urged to render advice to the best of their ability. A meeting of the General Advisory Board of Past Presidents shall be held at each Annual Convention of Delegates, the purpose of which will be to discuss problems of the Association, make recommendations, and select not more than two of its members to present their recommendations to the House of Delegates.

This proposed amendment is submitted in accordance with a request to the 1954 House of Delegates by the Board of Past Presidents. It is the desire of the Past Presidents to be permitted to choose the day and time of their annual meeting.

Committee on Mental Health

Your Board recommends:

That Chapter VII, Sections 1, 20, 21 and 22 be amended by:

Sec. 1:

In the line 6th from the bottom of the By-Law, change the period following "(Section 19)" to a semicolon and add, "a Committee on Mental Health (Section 20);" also, in the 3rd line from the bottom, "(Section 20)" be changed to read "(Section 21)" and that "(Section 21)" at the end of the By-Law be changed to read "(Section 22)."

That the By-Law be further amended by inserting:

Sec. 20. MENTAL HEALTH, Appointment and Duties. — The Committee on Mental Health shall consist of five members. The President shall appoint four members, one from each medical district, one for one year, one for two years, one for three years and one for four years, and thereafter they shall be appointed for four years as the terms expire. The President shall also appoint each year one member at large for a term of one year. The chairman of this committee shall be selected by the President. The duties of this committee shall be to direct attention of members of the Association to affairs relating to the field of mental health, to make specific suggestions for action in the field of mental health, and to serve as liaison with other state organizations interested in mental health.

Section 20 shall then become Section 21.

Section 21 shall then become Section 22.

Section 22 shall then become Section 23.

Your Board further recommends that if this proposed amendment is approved, that each county medical society be urged to establish a similar committee.

Application for Membership

Your Board recommends:

That Chapter XI, Section 5 of the By-Laws be amended by:

(1) Striking out the words "registered physician" in line 6 following the word "legally" and substituting therefor the words "licensed doctor of medicine"

(2) Inserting the words "apply for" immediately before the word "membership" in line 8

(3) Deleting the words "and opportunity" from the beginning of line 9

(4) Deleting the phrase "to become a member" at end of the section in line 11

The amended By-Law to read:

Sec. 5. MEMBERSHIP IN COUNTY SOCIETY ONLY PORTAL TO F.M.A. AND A.M.A.—Each county society shall judge the qualification of its own members, but, as such societies are the only portals to this Association and to the American Medical Association, every reputable and legally licensed doctor of medicine who is practicing, or who will agree to practice, nonsectarian medicine, shall be privileged to apply for membership. Before a charter is issued to any county society, full and ample notice shall be given to every such physician in the county.

This change is recommended to clarify that a physician seeking membership in a county medical society is privileged to apply for membership rather than being "entitled to membership."

Recommendation—1956 Annual Meeting

That the Hotel Fontainebleau, Miami Beach, be designated as the site of the 1956 Annual Meeting. The By-Laws provide that the dates for the meeting shall be set by the Board of Governors.

The dates for the Eighty-First Annual Meeting in St. Petersburg were set for April 3-6, 1955.

An operating budget for the fiscal year beginning April, 1954, was presented by Dr. Samuel M. Day, Secretary-Treasurer, and approved as amended to increase the amount allocated for expenses of delegates to the A.M.A.

The following members, on recommendations of their local county medical societies, were elected to Honorary Membership: Kenneth M. Davis, H. Spurgeon Cherry, John F. Mason, Ernest B. Milam, Arthur J. Bieker Jr., Philip F. Prioleau.

Mr. Ernest R. Gibson was unanimously approved for the post of Managing Director at the April 28 meeting. Mr. Gibson had been serving in an acting capacity during the intervening year following the death of Dr. Stewart G. Thompson.

On September 19, Mr. W. Harold Parham was appointed Assistant Managing Director in addition to his position as Supervisor of the Association's Bureau of Public Relations.

Your Board is pleased to announce that a pension program for the employees of the Executive Office became effective April 1, 1954.

At the request of the Board, a Personnel Job Analysis was prepared by the Executive Office. Copies were sent to the entire membership. Your Board urges each member to study this analysis and to visit the headquarters in Jacksonville in order to observe the personnel at work and to become familiar with the numerous services available.

The directive of the 1954 House of Delegates to reword paragraph (4) of the report of the "Clinic" Committee of the Dade County Medical Association was complied with and a bill to define and regulate the use of the word "Clinic" is to be introduced into the 1955 State Legislature.

In compliance with directive of the 1954 House of Delegates, your Board gave careful study to a resolution from the Pinellas County Medical Society which requested the A.M.A. to set up a Council on Insurance. This resolution was also studied by the Committee on Medical Economics and their findings and recommendations are contained in the report of that committee. In view of these findings and the report of A.M.A. Delegate and Board Member, Louis M. Orr, your Board is of the opinion that the matters covered in this resolution are being taken care of by policies already in effect in the A.M.A. as far as it is possible, therefore, no further action is necessary.

The President appointed a Committee to Study Membership Classifications in response to a request from A.M.A. for standardization of nomenclature and provisions for including interns and residents.

Your Board carefully considered and approved the schedule to be followed at the Eighty-First Annual Meeting, as submitted by Dr. Chas. J. Collins, Chairman, Scientific Work Committee. This program as published in the March Journal and in the printed program departs from previous schedules in that some of the specialty groups have voluntarily arranged to hold their annual meetings during the annual convention on some day other than Sunday.

An additional innovation in the convention schedule this year is discontinuance of the "Smoker" on Monday evening, replacing it with a cocktail party immediately preceding the annual dinner on Tuesday evening. Attendance at the "Smoker" in recent years has been so heavy that this type of entertainment has become unwieldy and difficult to stage. As arranged this year one evening is left free from scheduled activity.

At the request of the Blue Shield Board of Directors, proposed amendments to Article III of the Charter of Blue Shield and Article I and Article II of the By-Laws of Blue Shield were carefully considered and approval of the proposed changes given. In substance these amendments, which now have been put into effect by Blue Shield, make members of the F.M.A. House of Delegates active members of Blue Shield.

Liaison to Board of Governors on Public Relations

The primary activity of your liaison officer has been the implementation of the long range Public Relations Program which was adopted by the House of Delegates in April, 1954. This program has proved to be very sound and no changes are recommended.

Strenuous effort has been made to visit county medical society officers, their public relations committees, and county society meetings to advise them of the program, the need for it, the policies involved, activities of other county societies and assistance available to them from the Association's executive office.

Definite progress is being made by the county societies with medical public relations. The development of new projects and vitalizing of old programs have become so numerous among the societies it is difficult to keep an inventory of their activities. This is most encouraging for the ultimate effectiveness of our programs depends upon the activities of individual physicians at the county level.

Emphasis has been placed upon coordination with allied groups, independent and governmental agencies, liaison between the American Medical Association, other state medical associations and our county medical societies.

A sixth member has been added to the Florida Medical Association's Public Relations Advisory Committee to assist with liaison and interprofessional relations with the Florida Bar.

This report would not be complete without an expression of appreciation to the Association's officers, members of the Board of Governors, the Public Relations Advisory Committee, and the executive office staff for their cooperation in promoting the principles contained in our Public Relations Program.

Edward Jelks

Sub-Committee to Board of Governors on Veterans Care

The most important activities of this committee during the past year were to work on informing the doctors of the evils of the Veterans Administration program of non-service-connected disabilities. Dr. James L. Bradley of Fort Myers presented programs to the Pinellas County Medical Society, the DeSoto-Hardee-Highlands-Glades County Medical Society, the Polk County Medical Association, and the Sarasota and Manatee County Medical Societies.

Dr. George M. Stubbs of Jacksonville, a member of the sub-committee, made a talk to the St. Johns County Medical Society and to the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society.

Your chairman presented programs at the Alachua County Medical Society, the Lake County Medical Society, the Brevard County Medical Society, the Seminole County Medical Society, the Orange County Medical Society and the Nassau County Medical Society.

Your chairman attended the winter meeting of the Florida Department of the American Legion, with Dr. Thomas H. Bates of Lake City. We presented our program and much discussion followed. It is planned that a program on this subject will be presented at every county medical society in the state.

During 1953, $338,803 was paid to the doctors of Florida by the Veterans Administration, for the care of veterans being treated for service-connected disabilities. In 1954, $346,813 was paid out to members of the Florida Medical Association for the same care.

Your chairman conferred with members of the Veterans Administration and we have prepared a new booklet containing the details of treating veterans on a fee basis and containing a schedule of fees. This booklet will be published and issued in the near future.

Frederick H. Bowen, *Chairman*

Sub-Committee to Board of Governors on Blue Shield

Blue Shield of Florida, Inc. had a very successful year in 1954. The Plan had a gross income of $3,946,662.99—82.4 per cent of which was paid back in claims, 11.7 per cent was used for operating expenses and 5.9 per cent was added to reserves. At the same time, the Plan's membership increased by slightly over 70,000 new members.

During the year, the Board of Directors of Blue Shield deemed it advisable to refer two problems to the Board of Governors for its recommendations. The first problem was the payment to a participating physician for operative assistance in a surgical case, and the Board of Governors recommended to Blue Shield that in these instances, 20 per cent of the surgical fee be payable to a participating physician for operative assistance, to be deducted from the surgical fee payable for that case. This recommendation was accepted by the Blue Shield Board. The other problem was the question of a subscriber using the services of an osteopathic physician or surgeon, and

the Board of Governors in March 1954 recommended to the Blue Shield Board of Directors that Blue Shield reimburse the patient for osteopathic services. The Blue Shield Board accepted the recommendation and has authorized payment to the subscriber of 75 per cent of the fee that would be paid had the subscriber used the services of a participating Doctor of Medicine.

David R. Murphey Jr., *Chairman*

Your Chairman wishes to take this opportunity to express personal appreciation to the members of the Board for their excellent cooperation and for the careful consideration with which they weighed matters which have come to the attention of the Board.

Supplement

This supplement to the Report of the Board of Governors is in addition to, and a part of, the original report as printed in the Handbook. It is submitted to include a meeting of the Board in Jacksonville on February 27.

Your Board after careful consideration approved:

1. The request of the Florida Academy of General Practice to use F.M.A. executive office facilities and personnel for quarterly mailing of the Journal of the Florida Academy of General Practice, this service to be rendered on a trial basis for one year, the Academy to pay all costs.
2. The recommendation of the Committee on Medical Economics to authorize Marsh & McLennan of Atlanta, Insurance Brokers, to act as the exclusive representative of the Association in attempting to negotiate contracts for group professional liability and group disability insurance for Association members. Additional information is contained in the supplemental report of the Chairman of the Committee on Medical Economics, Dr. Robert E. Zellner.
3. The recommendations of the Council on matters of differences and disagreements between members which had been referred to the Council. Your Board has complied with the recommendations and suggestions as submitted.
4. The request of the Chairman of the Committee on Tuberculosis and Public Health to endorse the establishment of a Rheumatic Fever and Rheumatic Heart Disease Case Register for the State of Florida; such register to be a joint endeavor of the Florida Heart Association, the National Children's Cardiac Hospital and the Florida State Board of Health.

Recommendation—Association Headquarters

On the basis of the report and recommendations of a sub-committee of the Board to Study Need for Additional Space for the Executive Offices, Dr. John D. Milton, chairman, your Board recommends:

> That, is recognition of the necessity for additional space to house the Executive Offices in the immediate future, the House of Delegates authorize the Board of Governors to study the relative merits of home ownership as compared to rental property and to act as determined to be in the best interests of the Association.

It was the unanimous opinion of the members present that the Association can best be served with the headquarters located in Jacksonville.

Your Board is pleased to announce that the required three-fourths of the county medical societies have ratified the Constitutional Amendment as recommended by the 1954 House of Delegates, which permits selection of convention sites more than one year in advance.

At the request of Blue Shield of Florida, Inc. and in accordance with their Constitution and By-Laws, nominees for vacancies in the Blue Shield Board of Directors were selected for presentation to the active members of Blue Shield. The slate from which these nominees were selected was presented to the Board by the Blue Shield Nominating Committee, Dr. Edward Jelks, chairman. Each member of this House is an active member of Blue Shield and is urged to attend its annual meeting on Wednesday, April 6, immediately following adjournment of the second meeting of the House of Delegates.

Your Board approved the recommendation of the Managing Director to reorganize the Executive Office to establish a Department of Publications, which will include The Journal, The Directory and related activities. Mr. Tom Jarvis is to be transferred from his position as Assistant Supervisor, Bureau of Public Relations, to head this new department. Mr. Jarvis' training and experience especially qualify him for this assignment. A replacement to assist the Public Relations Supervisor is contemplated at an early date.

On recommendation of the Brevard County Medical Society, Dr. William S. Hughlett was made an Honorary Member, in recognition of his distinguished record in the foreign missionary field.

Respectfully Submitted,
Duncan T. McEwan, *Chairman*

Dr. Milton: "Following the general recommendations of delegates from Duval and Palm Beach, the resolution presented by Dr. James L. Borland of Duval County Medical Society is approved as amended. In the third line, the word 'additional' shall be inserted between 'allow' and 'nominations.' In the fourth line, the words 'the officers and' shall be deleted. In the fifth line, a period shall be placed after the words 'annual meeting' and the remainder shall be deleted.

"I move it be adopted as amended."

Seconded by Dr. Cecil M. Peek.

Motion carried.

Resolution

Be it resolved that the House of Delegates of the Florida Medical Association request the Blue Shield Board of Directors to change the By-Laws or Charter of that Corporation to allow additional nominations for election of members of the Board of Directors to be made from the floor at the annual meeting.

Respectfully submitted,
James L. Borland, *Delegate*
Duval County Medical Society

Dr. Milton: "I am very happy to announce that there has been an emergency meeting of the Executive Committee of the Board of Directors of Blue Shield and they agree that this change will be made.

"Next, there is a resolution as printed in the Handbook on page 41 by the Brevard County Medical Society, passed on January 11, 1955.

"Again, we had some very excellent discussions. I am happy that Dr. Elmer Hess, President-Elect of the AMA was present and he gave us some very sage advice. Many of the members spoke both for and against this resolution and the committee also read the letters from the Putnam County Medical Society and the Lee-Charlotte-Collier-Hendry County Medical Society, together with a similar resolution from the Palm Beach County Medical Society.

"Following the recommendation of the Brevard County Medical Society with reference to indemnifying patients for the services rendered by non-participating physicians, after prolonged free discussion, which denoted serious interest on the part of all concerned, we approve in principle the recommendation of the Brevard County Medical Society that the Blue Shield Board of Directors be requested to give further study to this problem, and that this report, as rendered by Reference Committee No. 3, be published in The Journal.

"I move that this be approved as amended."

Seconded by Dr. Chas. W. Bartlett.

Motion carried.

Dr. Milton: "Next is a report that all of us hate to present, but it is necessary. This is the report of the Committee on Necrology, with its supplement, as presented by Dr. Alvin L. Stebbins."

Dr. Milton read the names of the members who have died in the past year.

The House of Delegates stood for a moment of reverent silence.

Report of Committee on Necrology

Alvin L. Stebbins, *Chairman*

During the last fiscal year our Association lost by death the members whose names are listed below:

Mitchell M. Andrews, Orlando
Louis B. Bouchelle, New Smyrna Beach
Joseph Feldman, Palm Beach
Hamilton B. Frobisher, Miami
Nonie W. Gable, St. Petersburg
Lewis W. Glatzau, Daytona Beach
Francis A. Gowdy, Fort Pierce
James C. Hardman, Miami
Charles E. Hebard, Tampa
David R. Kennedy, Paducah, Ky.
Eugene C. Lowe, Miami
Paul H. Martin, Jacksonville
George E. Miller, St. Petersburg
Bascom H. Palmer, Miami
Harry A. Peyton, Jacksonville
Charles H. Ryals, Grand Ridge
Lowell S. Selling, Orlando
Dorothy J. Speers, Titusville
Alexander G. C. Stetson, Lakeland
William M. Stinson, Jacksonville
Thos. H. Stokes, Pensacola
J. Dever Stuart, Miami
Frederick P. Swing, Fort Lauderdale
Ferdinand A. Vogt, Miami
Orin R. Yost, Ormond Beach

Supplement

Since the Handbook for Delegates was printed, the Association has lost by death the members whose names are listed below:

Gordon B. Taylor, St. Petersburg
Albert L. Ward, Port St. Joe

When possible, obituaries have appeared in The Journal relative to the deaths of these doctors. Tributes have been paid to them in the different communities where they have practiced.

May we at this time stand for a moment of silence in reverence and respect to the memory of our departed colleagues.

Respectfully submitted,
Alvin L. Stebbins, *Chairman*

Dr. McEwan: "I move that we have a rising vote of thanks for the hotel for all they have done for us."

The members stood in unison.

Dr. McEwan: "We also wish to thank the press for the excellent coverage and cooperation they have given us. We are very grateful also to the radio and TV stations for their assistance.

"According to our By-Laws, the next order of business is the election of officers which takes place at high noon."

Dr. Franklin J. Evans: "I move that the rules be suspended and that this House proceed with the election of officers."

Seconded by Dr. Herbert L. Bryans.

Motion carried unanimously.

The Chair asked for nominations for President-Elect and recognized Dr. Turner Z. Cason of the Duval County Medical Society.

Dr. Cason: "Over the years, I have tried to contribute my little bit to the profession in Florida. Nothing I have ever done has given me such pleasure as my mission this morning. Several times in the past a group of physicians has contemplated our candidates for the high position of President of the Florida Medical Association. All of them have been eminently fitted for the job. This time they are presenting, through me, a very able man, who will in every way well fulfil that mission.

"He is a graduate of a St. Petersburg High School. He received his B.A. from Ohio Wesleyan, his M.D. from Johns Hopkins. He served his internship and residency at the Hospital for Women in Maryland. He has practiced in St. Petersburg since 1930. He has been president of the Pinellas County Medical Society, first vice president of the Florida Medical Association, member of the Board of Governors of the Florida Medical Association. He has been Chairman of the Council and that job he did well. He is a fellow of the American College of Surgeons, and a fellow of the Southeastern Surgical Congress. He has been Chief of Staff at St. Anthony's Hospital and Chief of Surgery at Mount Park Hospital. He served during World War II as Chief of Surgery of Evacuation Hospital in E. T. O. He won the Bronze Star and is a colonel in the Reserve.

"It is a great honor and privilege to place in nomination for President of the Florida Medical Association the name of Dr. Francis H. Langley."

Dr. James R. Boulware Jr.: "Mr. President, Officers and Delegates: The Polk County Medical Society has designated me to second the nomination of Dr. Francis Langley. It is a personal pleasure to second Francis' nomination as I have worked under him as a district Councilor and I know that he will ably perform the duties and demands of the presidency of the Florida Medical Association. I second the nomination of Dr. Francis H. Langley as President-Elect of the Florida Medical Association."

Dr. William M. Rowlett: "Mr. President and Fellows in the House of Delegates: The delegation from Hillsborough County feels that outside of Pinellas County, we know more about Dr. Francis Langley than anyone else and we feel exactly like Micah, that great Hebrew Prophet of ancient times, who once said of a friend, 'What the Lord requires of him he does well and with humility.' That philosophy describes Dr. Francis Langley. What is required of him, he does well and with humility.

"In the last World War, he served our country well. He volunteered his service to the Army and was given the rank of major. He served with distinction and was decorated with five battle stars, the Bronze Star, and the Victory Medal. In the words of the prophet, he served our country well.

"He has also served his county society well as president, and he has served the Florida Medical Association in many positions. In the words of the prophet, Micah, exceedingly well.

"It gives me a great deal of pleasure to second the nomination of Dr. Francis Langley."

Dr. Herz: "I move that nominations be closed and the Secretary instructed to cast a unanimous ballot for Dr. Langley."

Seconded by Dr. Borland.

Motion carried.

The House rose in unison as Dr. Langley was escorted to the rostrum by Dr. James L. Borland and Dr. Turner Z. Cason.

Dr. Langley: "When a man comes to a position like this, he is always a little uncertain. This morning when I awakened, I wondered if this would go through. Gentlemen, may I thank you most sincerely. I shall try to do my level best for the Florida Medical Association. I will ask the cooperation of all of you, as I know I may. Thank you."

Dr. McEwan: "Thank you, Francis. I know the Association will be in good hands.

"Nominations are now in order for First Vice President."

Dr. Homer L. Pearson Jr.: "I am sure that nobody in this room knows who I am going to name. I would like to place in nomination for First Vice President of the Florida Medical Association the name of Dr. Thomas C. Kenaston of Cocoa."

Dr. Herbert L. Bryans: "I move that nominations be closed and the Secretary instructed to cast a unanimous ballot for Dr. Kenaston."

Seconded by Dr. Herschel G. Cole.

Motion carried.

Dr. Kenaston: "Thank you very much, and I am sure Homer did not know himself who he was going to nominate."

The Chair called for nominations for Second Vice President.

Dr. Alvin L. Stebbins: "Members of the House of Delegates. I would like to place in nomination for Second Vice President, the name of a member of the Escambia County Medical Society who has served our county well. He has never been in a state position but I know that he will serve us well. I nominate Dr. Sidney G. Kennedy Jr. of Escambia."

Dr. Francis T. Holland: "I move that nominations be closed and the Secretary instructed to cast a unanimous ballot for Dr. Kennedy."

Motion seconded and carried.

Dr. McEwan: "Nominations are in order for Third Vice President."

Dr. Eugene G. Peek Jr.: "I would like to nominate my neighbor from Gainesville, Dr. Walter E. Murphree."

Dr. Raymond H. King: "I move that nominations be closed and the Secretary instructed to cast the ballot for Dr. Murphree."

Seconded by Dr. Cecil M. Peek.

Motion carried.

Dr. McEwan: "Nominations are in order for the office of Secretary-Treasurer."

Dr. Jere W. Annis: "I am back again to renominate Sam Day for the good job he has done."

Dr. Samuel G. Hibbs: "I move that nominations be closed and the President be instructed to cast a unanimous ballot for Dr. Day."

Motion seconded and carried.

The Chair asked for nominations for Editor of The Journal.

Dr. Franz H. Stewart: "Mr. President, Gentlemen: Breakfast was awfully good this morning, it was good yesterday morning and I think it is going to be good tomorrow morning. That's like our Journal. Every month The Journal comes out and it is good. I think it will be good next month and will keep on reflecting credit on the profession in Florida. I should like to place in nomination the name of Dr. Shaler Richardson as Editor of The Journal."

Dr. Chas. W. Bartlett: "I move that nominations be closed and the Secretary instructed to cast a unanimous ballot for Dr. Richardson."

Seconded by Dr. Herschel G. Cole.

Motion carried.

Dr. Richardson rose and was applauded.

Dr. McEwan: "I am very happy this morning to turn over our Association to a very capable man. I don't know any one who has done more.

"I would like Dr. Homer Pearson and Dr. A. Buist Litterer to escort Dr. Milton to the Chair."

As Dr. Milton was escorted to the rostrum, the House rose in unison and applauded.

Dr. McEwan: "I welcome you here and know you are going to do a wonderful job. The Association wishes to present to you your gavel which I know you will use with great care. It is a great privilege and honor to present this gavel to you and turn over to you the office of President of the Florida Medical Association."

Dr. Milton: "I accept the gavel and I hope I know what to do with it. I assure you I will do my utmost to carry out the work of this Association and hope we can do it with expedience. We have some committees that will help us have a good medical association which will prosper, I am sure, because it will be you that is doing it and not I.

"Duncan, now I want to present to you a token from the Florida Medical Association. Actually, I don't want you to feel that it is exactly what it is called—a past president's button. It is that indeed but at the same time I don't want you to feel that your work is finished, because we can't just let a good man stop.

"Also, it gives me pleasure to present to you from the Florida Medical Association a Certificate of Honor as President in 1954."

Dr. McEwan: "Thank you, John."

Dr. Milton: "I have no speech. I just want to make one or two announcements.

"The Annual Meeting of Blue Shield will be held in this room immediately after the adjournment of our meeting.

"The Board of Governors will meet in Room A on the mezzanine as soon as the Blue Shield meeting is over."

There being no further business, on motion from the floor, duly seconded and carried, the House of Delegates adjourned, sine die, at 12:15 p.m.

EIGHTY-SECOND ANNUAL MEETING

FLORIDA MEDICAL ASSOCIATION

HOTEL FONTAINEBLEAU

MIAMI BEACH

MAY 13-16, 1956

SCIENTIFIC ASSEMBLIES

First Scientific Assembly

The first Scientific Assembly convened at 9:45 a.m., Monday, April 4, in the Convention Hall with Dr. Jere W. Annis of Lakeland presiding. The following papers were read and discussed:

"What Is Your AMA?" Elmer Hess, Erie, Pa.

"Protein Bound Iodine — A Newer Aid in Medical Diagnosis," Nelson A. Murray, Jacksonville.

"Diabetic Neuropathy," Richard H. Sinden, St. Petersburg.

"Carcinoma of the Stomach: A Need for Earlier Diagnosis," Alton Ochsner, New Orleans.

"Recent Advances in the Treatment of Trigeminal Neuralgia," C. Ashley Bird, Jacksonville.

Second Scientific Assembly

The second Scientific Assembly convened at 2:00 p.m., Monday, April 4, in the Convention Hall with Dr. Annis presiding. The following papers were read and discussed:

"The Emergency Treatment of the Injured," Peter B. Wright, Augusta, Ga.

"Mediastinal Tumors," Hawley H. Seiler, Tampa.

"Treatment of Varicose Veins of the Lower Extremity by Stripping," James R. Anderson, West Palm Beach.

"Clinical Management of Peripheral Vascular Disease," Charles K. Donegan, St. Petersburg.

"Some Applications of Aortography," Ivan Isaacs, Jacksonville.

Third Scientific Assembly

The third Scientific Assembly convened at 2:00 p.m., Tuesday, April 5, in the Convention Hall with Dr. Donald F. Marion of Miami presiding.

First on the program was a symposium on "The Relationship of Nutrition in Pregnancy to the Newborn," sponsored jointly by the Florida Obstetric and Gynecologic Society and the Florida Pediatric Society. Co-moderators were Harold G. Nix, President of the Florida Obstetric and Gynecologic Society, and Lewis T. Corum, President of the Florida Pediatric Society, both of Tampa.

Taking part in the symposium were Winslow T. Tompkins, Associate Professor of Obstetrics and Gynecology, University of Pennsylvania Graduate School of Medicine, Philadelphia, and Jerome S. Harris, Chairman of the Pediatric Department of the Duke University School of Medicine and Duke Hospital, Durham, N. C.

After recess, the following papers were read and discussed:

"Reconstructive Surgery in Children," Clifford C. Snyder, Miami.

"Acute Renal Failure," Oscar W. Freeman Jr., Meredith Mallory, Fred Mathers and W. Dean Steward, Orlando. Presented by Dr. Freeman.

Fourth Scientific Assembly

The fourth Scientific Assembly convened at 9:00 a.m., Wednesday, April 6, in the Convention Hall with Dr. Marion presiding. The following case reports were read and discussed:

"Hematuria During Treatment of Malignant Hypertension with Hexamethonium Bromide," Bernard J. McCloskey, Jacksonville.

"Systemic Blastomycosis," Victor H. Knight Jr. and Wesley W. Wilson, Tampa. Presented by Dr. Knight.

A paper, "Contact Dermatitis," was presented by George E. Morris, Boston.

REGISTRATION

The registration for the Eighty-First Annual Meeting at St. Petersburg surpassed that of any previous convention of the Association. The total number registered was 1,665. The registrants include 783 members of the Association, 253 visiting physicians, 47 other guests, 356 members and guests of the Woman's Auxiliary, 6 scientific exhibitors, and 220 representatives of exhibiting firms. There were 29 other states, and 2 foreign countries represented.

Registration List

Officers

Duncan T. McEwan, M.D., President	Orlando
John D. Milton, M.D., Pres-elect	Miami
V. Marklin Johnson, M.D., 1st Vice Pres.	W. Palm Bch.
Frederick H. Bowen, M.D., 2nd Vice Pres.	Jacksonville
Rowland E. Wood, M.D., 3rd Vice Pres.	St. Petersburg
Samuel M. Day, M.D., Secy-Treas	Jacksonville
Shaler Richardson, M.D., Editor	Jacksonville

Members

ANNA MARIA: Edgar W. Huth. ARCADIA: Harold S. Agnew, Henry P. Bevis, F. Erwin Daves, Charles H. Kirkpatrick, Frank J. Liddy, Gordon H. McSwain. AVON PARK: Hubert W. Coleman, Donald C. Hartwell, Samuel A. King. BARTOW: Chester H. Murphy, William F. Peacock, Janet B. Sutton. BRADENTON: Alfons R. Bacon, Lowrie W. Blake, Alva J. Floyd, Joseph B. Ganey, Roy W. Gunther, Irvin E. Hall Jr., Willis W. Harris, Roderic O. Jones, Richard V. Meaney, John S. Neill, Harvey C. Pauley, Millard P. Quillian, Sidney Smith, Marjorie L. Warner, Willett E. Wentzel, Frederic H. Wood.

BRANFORD: Edward G. Haskell Jr. BREWSTER: Gerald W. Grawey. BROOKSVILLE: George R. Creekmore. BUSHNELL: Karl T. Humes. CALLAHAN: David D. Bennett. CHIPLEY: Martin L. Lane. CLEARWATER: M. Eldridge Black, Raymond H. Center, James C. Fleming, James V. Freeman, Lewis A. Gryte, V. LeRoy Hagan, Everett M. Harrison, Francis C. Hoare, Charles H. Johnson Jr., John T. Karaphillis, James B. Leonard, Samuel T. Register, George H. Schoetker, James M. Stem, Thomas H. Wallace, David M. Weible, Robert M. Wolff. COCOA: Thomas C. Kenaston.

CORAL GABLES: Jack Q. Cleveland, Franklin J. Evans, Robert P. Keiser, James F. Lyons, Wm. W. McKibben, Burton T. Meadows, William T. Mixson Jr., R. Sam Mosley, Wesley S. Nock, Frederick P. Poppe, Warren W. Quillian, Bernard Yesner. DADE CITY: Dwayne L. Deal, W. Wardlaw Jones, John S. Williams. DANIA: Fred E. Brammer.

DAYTONA BEACH: Fred H. Albee Jr., Charles A. Brown, John J. Cheleden, James W. Clower Jr., C. Robert DeArmas, David W. Goddard, Carroll V. Herron, Edward C. Love Jr., George H. McSwain, Edward P. Madden, James D. Moffett Jr., Achille A. Monaco, Howard W. Reed, Henry C. Weber. DeFUNIAK SPRINGS: William D. Cawthon. DELAND: Frank Valentine. DUNEDIN: Maurice E. Ross, Walter H. Winchester, Clifton A. Young.

EUSTIS: C. McK. Tyre. FORT LAUDERDALE: Norris M. Beasley, Curtis D. Benton Jr., Russell B. Carson, Alfred E. Cronkite, Burns A. Dobbins Jr., J. Allan Fields, John S. Fifer, Donald H. Gahagen, Francis C. Haberman, Rudolph W. Heath, Garland M. Johnson, Lloyd U. Lumpkin, Thomas L. McKee, Richard A. Mills, Richard D. Owen, George T. F. Rahilly, Leigh F. Robinson, Paul G. Shell, Vincent V. Smith, Curtis H. Sory, Charles L. Wadsworth, James M. Weaver, W. Dotson Wells, Scottie J. Wilson.

FERNANDINA BEACH: Henry B. Dickens Jr. FORT MYERS: Fred D. Bartleson, Ernest Bostelman, A. Louis Girardin Jr., Angus D. Grace, William H. Grace, H. Quillian Jones, Joseph L. Selden Jr., John S. Stewart, Baker Whisnant. FORT PIERCE: Robert F. Meeko, Adrian M. Sample, Laurance D. Van Tilborg, Maltby F. Watkins, Lester L. Whiddon. GAINESVILLE: Henry J. Babers Jr., F. Emory Bell, Charles H. Carter, Allen Y. DeLaney, George L. Emmel, Raymond J. Fitzpatrick, Charles H. Gilliland, George T. Harrell Jr., Carl M. Herbert, Albert G. Love IV, James M. McClamroch, John E. Maines Jr., Walter E. Murphree, Charles Pinkoson. GRACEVILLE: Redden L. Miller. GROVELAND: John D. Bloom. GULFPORT: James M. Neill. HIALEAH: Leon S. Eisenman. HOLLYWOOD: Andre S. Capi, Anthony C. Galluccio, John H. Mickley. HOMESTEAD: Joseph H. Shain, Roston M. Williamson.

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ST. PETERSBURG: Harry L. Allan Jr., Arnold S. Anderson, Clyde O. Anderson, George H. Anderson, Arthur Appleyard Jr., Charles E. Aucremann, Grover W. Austin, Walter H. Bailey, Kenneth A. Baker, Russell C. Bane, Bernard T. Bell, Paul L. Berezney, Carl Z. Berry, John P. Boyle, John R. Butter, Elmer B. Campbell Sr., Elmer B. Campbell Jr., Edward L. Cole Jr., John H. Cordes Jr., Harry R. Cushman, Thomasson P. Dann, Virgil C. Daniels Jr., William M. Davis, William J. Dean, Reid E. Dicks, Luverne H. Domeier, Charles K. Donegan, Woodrow B. Estes, Ira C. Evans, William P. Farber, Chas. L. Farrington, John P. Ferrell, Earl R. Fox, Cornelius S. Franckle, Albert R. Frederick, Leonard Freed, William D. Futch, Linwood M. Gable, N. Worth Gable, Rodes C. Garby, Allyn B. Giffin, Chester L. Goodnow, Abraham J. Gorday, James L. Gouaux, George O. Gundersen, Joseph V. Hammel, Dean W. Hart, Eugene H. Heibner, Paul S. Herr, G. Frederick Hieber, George B. Hobach, Frank Holecek, David S. Hubbell, Henry J. Jensen, James F. Jones, William E. Kendall, Peter B. Kersker, Robert M. Kilmark, Howard P. Knapper, Frederick C. Knight, Roscoe H. Knowlton, E. Ransom Koontz, Francis H. Langley, Howard F. Lawrence, Donald E. McClanathan, Whitman C. McConnell, Whitman H. McConnell, James H. McRae, Norval M. Marr Sr., Norval M. Marr Jr., David L. Mendelblatt, Robert B. Mertz, Alvin L. Mills, Maximilian W. Moeller, Daniel F. H. Murphey, Ralph D. Murphy, Earl P. Myhree, Orville N. Nelson, John B. O'Neill, David T. Overbey, R. Wynn S. Owen, Harrison G. Palmer, Nell T. Pattengale, Joseph W. Pilkington, Edward V. Pollard, William G. Post Jr., Frank L. Price, Joseph J. Regan, H. Milton Rogers, Franklin W. Roush Jr., John P. Rowell, Councill C. Rudolph, Harry R. Sackett, Alfred P. Seminario, John E. Shay, Richard H. Sinden, Benjamin H. Sullivan, Nathaniel C. Tomson, Hugh W. Wade, Barzillia R. Waldron, Kenneth W. Watterson, James L. West Jr., Ruth Winston, Alvin J. Wood, Rowland E. Wood, Claude B. Wright.

SANFORD: J. Clifford Boyce, Daniel H. Mathers, John M. Morgan, Charles L. Park Sr. SARASOTA: John M. Butcher, George M. Coggan, Francis M. Crage, Thomas G. Dickinson, Michael A. DiCosola, Lloyd J. Duest, Ernest M. Grochowski, Joseph Halton, Harold T. Lawler, Eugene D. Liddy Jr., Henry G. Morton, Robert O. Pitts, J. Sturdivant Read, Hugh G. Reaves, Karl R. Rolls, Thomas F. Scott Jr., William A. Shannon, Melvin M. Simmons, John A. Tasche, Thomas W. Taylor, Henry J. Vomacka, Samuel R. Warson, Millard B. White, Thomas R. Young Jr.

SEBRING: Zaven M. Seron. STARKE: Andrew J. Barry. STUART: Walter F. Davey, John M. Gunsolus. TALLAHASSEE: Edson J. Andrews, Thomas J. Bixler, Merritt R. Clements, Paul J. Coughlin, Francis T. Holland, William J. Hutchison, Charles F. James Jr., J. Elizabeth Jeffress, Odis G. Kendrick Jr., Nelson H. Kraeft, David J. McCulloch, Lawrence C. Manni, Robert H. Mickler, George S. Palmer, Henry L. Smith, Jr.

TAMPA: Frank S. Adamo, Samuel H. Adams, Chadbourne A. Andrews, Efrain C. Azmitia, Richard A. Bagby, Collin F. Baker Jr., Chas. W. Bartlett, Heyward J. Blackmon, William C. Blake, Ernest R. Bourkard, C. MacKenzie Brown, Harold O. Brown, Joseph D. Brown, J. Robert Campbell, Leffie M. Carlton Jr., Harold Carron, Frank V. Chappell, M. Austin Chardkoff, C. Frank Chunn, Herschel G. Cole, Lewis T. Corum, Eugene F. Costantino, Marvin L. Cullen, Rosalind E. Cummings, Joshua C. Dickinson, R. Renfro Duke, Wm. P. Duncan, Thomas M. Edwards, Oren A. Ellingson, J. Brown Farrior, Celestino G. Fernandez, Gaetano C. Ferrante, Elsie M. Gilbert, Chas. McC. Gray, Stephen P. Gyland, H. Phillip Hampton, Ralph T. Health, John S. Helms, Linus W. Hewit, Samuel G. Hibbs, James B. Hodge, J. M.

Ingram Jr., A. M. C. Jobson, Oscar A. Juarez, Victor H. Knight Jr., Eugene A. Kraemer, Frank T. Linz, Warren T. Loftis Jr., Blackburn W. Lowry, Myron L. McEachern, Thomas E. McKell, A. Ziegler McPherson, Douglas D. Martin, Alfonso F. Massaro, Eugene B. Maxwell, Benjamin J. Meadows, Frank C. Metzger, Joseph A. Minardi, David R. Murphey Jr., Robert G. Nelson, Harold G. Nix, Hugh E. Parsons, Julien C. Pate Sr., Julien C. Pate Jr., Joseph A. Pendino, Neal J. Phillips, William M. Rowlett, Clarence A. Rudisill, Joseph J. Ruskin, James M. San, Joseph D. Scolaro, Hawley H. Seiler, Edward F. Shaver, Marshall E. Smith, Philip L. Smoak, Louis A. Spicola, Alvord L. Stone, Wray D. Storey, Harold Sutker, Joseph W. Taylor Sr., Joseph W. Taylor Jr., Mason Trupp, Morris Waisman, Augustine S. Weekley, Walter H. Wellborn Jr., Albert A. Wilson, Frances C. Wilson, Wesley W. Wilson, James A. Winslow Jr., Robert W. Withers.

TARPON SPRINGS: James E. Thompson. TAVARES: James R. Hanson. TITUSVILLE: James F. Speers. VENICE: Samuel E. Kaplan, Douglas R. Murphy. VERO BEACH: Erasmus B. Hardee, Kip G. Kelso, Enoch J. Vann Jr. WEST PALM BEACH: James R. Anderson, Robert V. Artola, Harry E. Bierley, William E. Bippus, Edwin W. Brown, Victor Clarholm, Thomas E. Daly, Joseph J. Daversa, C. Jennings Derrick, Hugh Dortch Jr., William H. Everts, Charles McD. Harris Jr., Guy W. Heath, Frederick K. Herpel, Lorenzo James, V. Marklin Johnson, R. Gaylord Lewis, W. Ambrose McGee, David W. Martin, Walter R. Newbern, Ralph M. Overstreet Jr., Cecil M. Peek, Raymond S. Roy, William Y. Sayad, Murray D. Sigman, Joseph R. Skyer, Roslyn Skyer, James R. Sory, Younger A. Staton.

WEWAHITCHKA: Harold B. Canning. WINTER GARDEN: Edward Bradford, Albert H. Gleason. WINTER HAVEN: Chester L. Nayfield, Lee E. Parmley. WINTER PARK: George R. Crisler, Ruth S. Jewett, Walter B. Johnston, Albert C. Kirk Sr., Frank W. Nickel, Henry J. Wiser. ZEPHYRHILLS: Harry G. Brownlee.

Visiting Doctors

ARCADIA: August C. Herman, Joseph W. Lawrence. AUBURNDALE: Paul A. Tanner Jr., Terry F. Tanner. BAY PINES: Thomas M. Dunn. BRADENTON: James B. Anderson, S. J. Hillis. BROOKSVILLE: Richard A. Henry. CLEARWATER: John C. Adams, John U. Buchanan. CORAL GABLES: Joseph R. Galluccio, Carlos G. Llanes, Jack Reiss. DAYTONA BEACH: Beverly H. White. DUNEDIN: Edward W. Johannes, J. U. Keating, Hermenegild Klima. FORT LAUDERDALE: Roger K. Haugen. FORT MYERS: Gustave F. Bieber. GAINESVILLE: Clara P. Haupt. GULFPORT: Richard M. Free. JACKSONVILLE: Reginald V. Berry, Ralph W. McComas, William H. Mathews. LAKE WORTH: Richard F. Kidder. LANTANA: Antonio V. Camera, William L. Potts.

LARGO: Harry M. Katz. MIAMI: Thomas J. Baker, William Corwin, John J. Farrell, David Feigenbaum, James J. Goodman, H. Carlton Howard, Robert B. Lawson, Wm. P. Murphy, Lloyd R. Newhouser, O. A. Smith, Leo H. Wilson Jr. MIAMI BEACH: Harold D. Van Schaick. MULBERRY: Charles W. Richardson. NAPLES: Francis Ford. QUINCY: Frank J. Hill. REDINGTON BEACH: William J. Bailey. ST. PETERSBURG: Leo Ariel, Frank A. Barlow, Mayer Bernstein, Joseph C. Brettner, H. W. Carter, Paul C. Clark, Louis H. Clerf, Milton B. Cole, David K. Davis, E. F. Dougherty, Rudolph C. Garber Jr., A. E. Gehrke, Milton R. Himalstein, Chester F. Johnson, Robert C. Judd, Alfred D. Koenig, Goldson T. Lamon, Robert J. Link, E. V. McCormick, Raymond J. Malzone, Vitus W. Manginelli, Leroy Scott Moore, H. Gerald Morin, Francis Neumayer, William S. Owen, Geo. J. Race, Maurice A. Strickland, R. C. Szabo, Lyman O. Warren, Walter M. White Jr.

TALLAHASSEE: Thomas E. Hodgins Jr., DeHart Krans. TAMPA: Frank Cline Jr., Frederick W. Grover, Robert G. Iglesias, Sae Sodn Lee, Francis M. Sack, Myrtle Sweimler, F. H. Toledo. WAUCHULA: Alfred G. Smith.

ALABAMA-BIRMINGHAM: James F. Cason, Benjamin F. Morton. CALIFORNIA-REDONDO BEACH: W. A. Bailey. DELAWARE-HARRINGTON: Hewitt W. Smith. GEORGIA-ATLANTA: Edgar Boling. AUGUSTA: Grady O. Haynes, Peter B. Wright. FOLKSTON: Joseph M. Jackson Jr. GAINESVILLE: Oliver T. Ghent. THOMASVILLE: M. M. Van Sandt. WARRENTON: Hubert B. Cason. ILLINOIS-CHICAGO: Edward E. Avery, Robert J. Craven, Edward L. Jenkinson, Lawrence A. Sadlek, John C. Thill. DECATUR: Ferris D. Highsmith. EVANSTON: George C. Turnbull. HIGHLAND PARK: Albert H. Slepyan. NORMAL: Leon T. Fruin. OTTAWA: Matthias H. Sawyer. PEORIA: William Cooley Jr., William M. Cooley Sr. INDIANA-ANDERSON: Warren C. Polhemus. EVANSVILLE: Paul A. Clouse. FORT WAYNE: Ralph H. C. Beams, John W. McCallister, Edgar N. Mendenhall, Samuel R. Mercer, Noah A. Rockey. GARY: Herbert M. Baitinger. GREENCASTLE: Dick J. Steele. INDIANAPOLIS: Calvin B. Fausset, William D. Gambill. MUNCIE: Charles R. Alvey. WINDFALL: Elmer B. Moser. IOWA-BURT: John G. Clapsaddle. CLEAR LAKE: Dean W. Clapsaddle. HOWARDEN: Marvin O. Larson. MASON CITY: Egmont H. Barg, Albert E. Hale, James W. Lannon.

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MICHIGAN-ANN ARBOR: Edward P. Smith Jr. BAY CITY: Leonard D. MacRae. DETROIT: Charles F. Dodenhoff, Thomas Ganos, Leland V. Hewitt. DOWAGIAC: Sherman L. Loupee. EVART: Jacob Bruggema. LANSING: Kenneth J. Feeney, Leo W. Walker. PAW PAW: Arthur H. Steele. PONTIAC: Robert L. Segula. YPSILANTI: Donald W. Martin. ZEELAND: Cornelius E. Boone. MINNESOTA-DETROIT LAKES: Lloyd H. Rutledge. DULUTH: Charles M. Jessico, Owen G. McDonald, Thomas O. Young. MAPLE LAKE: William E. Hall. MINNEAPOLIS: Reuben F. Erickson, Lucius H. Fowler, Cyrus O. Hansen, Karl E. Sandt. ROCHESTER: James O. Fergeson. WINONA: Charles P. Robbins.

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PENNSYLVANIA-EMPERIUM: W. H. Bush. ERIE: Elmer Hess. NEW KENSINGTON: Albert R. Kaufman. OAKDALE: Franklin W. Mathewson. PHILADELPHIA: Milton Sarshik, Winslow T. Tompkins. PITTSBURGH: Antonio Bianco, William C. Porter Jr. RHODE ISLAND-PROVIDENCE: Howard Umstead. SOUTH CAROLINA-SPARTANBURG: George W. Price Jr. TENNESSEE-BRISTOL: Arthur B. English. JOHNSON CITY: Lee K. Gibson. KNOXVILLE: A. L. Jenkins. TEXAS-EL PASO: Leslie M. Smith. VIRGINIA-DORCHESTER: Charles R. Jones. HAMPTON: Mortimer M. Elkind. WEST VIRGINIA-CHARLESTON: Henry M. Escue. FAIRMONT: Emery D. Wise.

WISCONSIN-GREEN BAY: I. E. Levitas. MADISON: Donald M. Britton, William J. Ganser, Palmer R. Kundert, William A. Tanner. MILWAUKEE: Richard E. Stockinger. RACINE: Frank B. Marek, George D. Skow. WAUWATOSA: Kenneth A. Seifert. CANADA-MANITOBA-WINNIPEG: A. M. Campbell. ONTARIO-BALA: David A. Henderson. GUELPH: William V. Harcourt. LONDON: R. M. McFarlane, William P. Tew. NORTH BAY: H. M. Wallace. OTTAWA: Frederick W. Jeffrey, E. W. Lidington. PORT ARTHUR: Charles E. Baker. SARNIA: James F. Roberts, Gordon R. Scarrow. TORONTO: Douglas J. Galbraith. WAUBAUSHENE: J. A. Campbell. WINDSOR: Louis H. Lager. PUERTO RICO-SAN JUAN: Mauricio Rubio.

Annual Joint Report of Secretary-Treasurer, Samuel M. Day, M.D. Managing Director, Ernest R. Gibson

The Association continues its steady growth, keeping pace with the remarkable increase in population and rapid expansion of the state. At the end of the fiscal year, March 20, 1955, the total membership was 2,743. This represents a net increase of 206.

The executive offices are located at 128 East Forsyth Street, Jacksonville. Members are urged to visit the offices and to utilize the many services available. The organizational plan divides these offices and their activities into Administration, or general office procedures, the Department of Publications and the Bureau of Public Relations.

ADMINISTRATION

The general office is under the direction of Mrs. Zoe Pack, Office Manager, senior employee in years of service. Other employees in the order of seniority are: Mrs. Mae Mason, Misses Frances Pesce and Helen Vathis, and Mrs. Eileen Dahl. It is in this division of the executive offices that the all-important records of membership are kept current, both for F.M.A. and A.M.A. Here the essential bookkeeping is done and an astounding amount of daily correspondence is handled. Another major activity is the physicians' placement service which endeavors to get physicians seeking locations in contact with those communities which are seeking doctors. Assistance is provided, as required, to the Board of Governors, the Council and the chairmen of the several committees.

Exhibits

As in the past, the success of our 1955 Convention in St. Petersburg was due in no small part to the technical exhibitors. These exhibiting firms display products and equipment of value to the members and much scientific information is available in this manner. The gross income from this source amounting to over $14,000 for the year 1955 is a substantial contribution to the Association's total income.

DEPARTMENT OF PUBLICATIONS

This newly established division of the executive offices is headed by Mr. Tom Jarvis, previously assistant to the supervisor of the Bureau of Public Relations. He is aided by Mrs. Louise Rader, journal technician. Included among the major activities assigned to this department are The Journal, the Directory, Briefs and miscellaneous publications and printing. Mr. Jarvis also supervises the operation and maintenance of general office equipment.

The Journal

The number of Journals printed during the past fiscal year totaled 34,444 which represents a net increase of 1,424 over the previous year.

The cost of printing The Journal continues to advance, both in increased cost of printing and paper stock. A more detailed report of The Journal is contained elsewhere in this issue in the Report of the Editor.

Medical Directory

One copy of the 1955 Florida Medical Directory was mailed to each active member, without charge, in January. Additional copies are available at $2.00 each. Direct sales produced a revenue of over $2,000. The cost of printing the Directory has also increased yearly, due not only to the increased price of printing and paper, but also to the steady increase in the number of medical doctors holding Florida licenses.

Briefs

Every attempt is made to keep the members as well informed as possible. This is accomplished mainly through the Association's newsletter, "Briefs." "Briefs" is sent to every member but it is not issued on an established schedule. It is sent only when it is believed that there is information of value to be disseminated. The items are intentionally kept short, informal and newsy.

BUREAU OF PUBLIC RELATIONS

The policies of the Bureau are determined by the Board of Governors and implemented through its Liaison Member for Public Relations and the Committee on Legislation and Public Policy. The Bureau is directed by W. Harold Parham, supervisor, who also serves as the Association's assistant managing director. A new assistant supervisor of the Bureau has been selected to replace Mr. Jarvis who now heads the recently organized Department of Publications. Mrs. Barbara Martin serves as secretary for the Bureau.

Primarily the Bureau has been engaged in promoting, planning and coordinating the Association's Public Relations and Legislative programs. The public relations program is outlined in the Association's publication entitled "A Positive Program of Public Relations."

Field work has taken a great deal of the time of the Bureau's staff. The officers and committee chairmen of every county medical society have been contacted, many on several occasions, to promote and coordinate the programs over the state. Various State of Florida officials, legislators and other influential individuals, newspapers, radio and television stations, allied and civic organizations have been contacted in an effort to bring about a closer relationship and better understanding of the Association's objectives and activities.

Following expansion of the Rural Health Program in cooperation with the Florida Agricultural Extension Service of both state universities, the State Board of Health and the Florida Farm Bureau Federation, the Program has been instituted in a pilot county under leadership of the county medical society. An innovation to the Program has been the Florida Medical Association Award for health achievement presented this year for the first time to a farm youth. As in the past, physician speakers, literature, displays and special services have been supplied to rural groups.

Publicity for the Association's annual convention, district meetings and other activities of interest have been processed by the Bureau. Health Topics on items of medical interest have been supplied regularly to weekly newspapers. Transcribed programs on health subjects have been distributed in cooperation with county medical societies for broadcasting by local radio stations.

Fair exhibits were displayed at the Pensacola Interstate Fair, the North Florida Fair, Florida Citrus Exposition, Florida State Fair and the Central Florida Fair. All showings were co-sponsored by the respective county medical society and the Association.

County medical societies have been assisted by the Bureau with special projects, such as medical forums, live radio and TV programs, exhibits, improving emergency call services, press-radio-television relations and other general public relations activities.

The Bureau has assisted the Committee on Legislation and Public Policy in coordinating and carrying out projects pertaining to national legislation and our state legislative program. The Supervisor served in an administrative capacity to the Committee on Indigent Hospitalization appointed by the Governor of Florida to study the problem of medical care for the indigent and to submit recommendations for presentation to the legislature.

The responsibility for local public relations projects rests with the respective county medical societies. The facilities of the Bureau are available to county medical societies for assistance with local programs. The societies are urged to use these facilities.

FINANCES

Receipts for the Fiscal Year, ending March 20, 1954, totaled $139,907.73 and the disbursements were $143,246.93. The excess of disbursements over receipts is due to non-budgeted expenses in connection with the A.M.A. Clinical Session in Miami and advance payments on premiums for the employee pension program in order to take advantage of an appreciable discount.

Although there appears to be some indication of a leveling off, the current expenditures indicate that the expenses of operating the Association are still increasing, due to enlarged membership and additional activities. It is anticipated that the coming year will find prices of many items still higher.

The financial statements appearing at the end of this report are published for the information of the members. The books and records of the Association are open to the members and we will gladly endeavor to answer inquiries of any nature upon request. The books have been audited by Goodrich & Varnedoe, Certified Public Accountants, and a certificate of the audit is incorporated in the statements which follow.

Respectfully submitted,
Samuel M. Day, M.D., *Secretary-Treasurer*
Ernest R. Gibson, *Managing Director*

April 27, 1955

Dr. Samuel M. Day, Secy.-Treas.
Florida Medical Association
Jacksonville, Florida

Dear Sir:

In compliance with request of Mr. Ernest R. Gibson, Managing Director, Florida Medical Association, we have examined the books of account, vouchers and other records of the association, maintained in his office, for the period March 21, 1954, to and including March 19, 1955, and submit herewith our report consisting of:

EXHIBIT "A" — Statement of Assets and Liabilities, March 19, 1955.

EXHIBIT "B" — Statement of Receipts and Disbursements for the Period March 21, 1954 through March 19, 1955.

We determined that all recorded receipts were deposited to the credit of the association, and that the disbursements appeared to be for proper purposes. The item on the liabilities side of Exhibit "A," under caption "Deferred Income" is the aggregate of the membership dues unpaid as at March 19, 1955 and the amount due the Journal Fund by advertisers.

The investments in U.S. Treasury and Savings Bonds were verified by actual count in the Safe Deposit Vault. Matured interest coupons totaling $600.00 were attached to coupon bonds on date of verification. It is our suggestion that these coupons be clipped and presented for payment.

An Employee Pension Trust Plan was established during the year ended March 19, 1955 for which the Association expended $25,904.03.

The records of the various County Societies were inaccessible and, therefore, we made no attempt to verify remittances for dues, nor did we confirm the balances due the association for advertising in the Journal.

Yours very truly,
(Signed) Goodrich & Varnedoe
Certified Public Accountants

CHG/d

Exhibit "A"
Statement of Assets and Liabilities
March 19, 1955

Assets			
Cash in Bank:			
Atlantic National Bank—			
Checking A/c	$106,477.55		
Florida National Bank—			
Checking A/c	23,151.42		
Atlantic National Bank—			
Savings A/c	9.17		
Barnett National Bank—			
Savings A/c	1,979.61	$131,617.75	
Petty Cash Fund			25.00
Accounts Receivable:			
General Fund	$ 31,480.00		
Journal Fund	1,712.91		33,192.91
Inventory —			
Stationery, Etc.			2,335.11
Investments:			
U. S. Treasury and Savings Bonds			45,995.87
Furniture & Fixtures:			
General Fund	$13,476.04		
Less Depreciation Reserve	5,766.34	$ 7,709.70	
Bureau of Public Relations Fund	$ 5,191.83		
Less Depreciation Reserve	1,802.22	3,389.61	11,099.31
TOTAL ASSETS			$224,265.95
Liabilities			
Deferred Income			$ 33,192.91
Net Worth			191,073.04
TOTAL LIABILITIES AND NET WORTH			$224,265.95

Exhibit "B"
Statement of Receipts and Disbursements
March 21, 1954 Through March 19, 1955

Balances — March 21, 1954		
Atlantic National Bank—Checking A/c	$120,258.17	
Florida National Bank—Checking A/c	12,729.63	
Atlantic National Bank—Savings A/c	9.17	
Barnett National Bank—Savings A/c	1,959.98	$134,956.95
Receipts		
Back Dues	$ 29,920.00	
Current Dues	66,760.00	
Entrance Fees	2,810.00	$ 99,490.00
Interest on Savings Accounts	19.63	
Miscellaneous Income	854.88	
Advertising—Journal	$ 21,246.55	
Directory	805.00	22,051.55
Journal Subscription and Sales	580.17	
Directory Sales	2,023.00	
Technical Exhibits	13,580.00	
Convention Smoker	1,308.50	
TOTAL RECEIPTS		139,907.73
TO BE ACCOUNTED FOR		$274,864.68
Disbursements		
Administrative:		
Postage and Express	$1,143.62	
Office Supplies	1,167.97	
Telephone & Telegraph	914.87	
Travel Expense—Managing Director	940.20	
Delegates to A. M. A. (3)	1,681.32	
Office Rent	3,325.00	
Bank Exchange	6.23	
Treasurer's Bond	225.50	
Employer's Liability Insurance	48.37	
A. M. A. Clinical Session	6,491.26	
Maintenance—Office Equipment	338.94	
Rental Safety Deposit Box	12.50	
Blue Cross & Blue Shield (Assn. Employees)	192.00	
Federal Tax	557.72	
State Sales Tax	935.71	
Federal Excise Tax	59.30	
Furniture and Fixtures	2,094.11	
Books, Pamphlets, Etc.	441.29	
Payrolls	27,130.28	
Contractor Fees	2,808.00	
Employee Pension Trust Plan	25,904.03	
Employee Pension Trust—Trustee Fee	140.40	
Journal Printing and Paper	22,288.00	
Dray	123.60	
Printing & Engraving	2,884.48	
Directory Printing, Etc.	2,392.23	
Convention Expense	4,381.24	
Miscellaneous Committee Expense	768.93	
Conv. Smoker, Etc.	2,655.50	
Dues:		
Medical Society Exec. Conference	15.00	
Rotary Club	91.00	
Conference of Presidents	131.72	
Christmas Party—Staff	21.54	
Electrical Installations and Supplies	65.40	
Porter Service	12.70	
Advertising	6.48	
Incidental	27.25	
TOTAL ADMINISTRATIVE		$112,423.69
Bureau of Public Relations:		
Postage and Express	$1,200.00	
Office Supplies	649.80	
Payrolls	13,214.10	
Contractor Fees	90.00	
Insurance—Blue Cross and Blue Shield (Ass'n Employees)	81.60	
Telephone & Telegraph	1,208.11	
Travel Expense—Supervisor and Assistant	3,492.19	
Federal Tax	341.51	
State Sales Tax	140.02	
Federal Excise Tax	24.51	
Furniture & Fixtures	1,188.08	
Office Rent	1,652.00	
Books, Pamphlets, Etc.	462.10	
Printing & Engraving	1,196.14	
Maintenance—Office Equipment	136.44	
Legislation, Public Policy	1,660.95	
Special Projects	3,820.22	
Porter	19.70	
Dues:		
Chamb. of Commerce —Membership	100.00	
Medical Society Executive Conference	15.00	
The Exchange Club	48.00	
Florida Press Ass'n.	50.00	
Comprehensive & Liability Auto Insurance—Employees	31.15	
Advertising	1.62	
TOTAL BUREAU OF PUBLIC RELATIONS	30,823.24	
TOTAL DISBURSEMENTS		143,246.93
Balance — March 19, 1955		$131,617.75
Balance Comprised of:		
Atlantic National Bank—Checking A/c	$106,477.55	
Florida National Bank—Checking A/c	23,151.42	
Atlantic National Bank—Savings A/c	9.17	
Barnett National Bank—Savings A/c	1,979.61	$131,617.75

(Continued on page 1072)

Report of Editor of The Journal
Shaler Richardson, M.D.

This is the forty-second year of publication of The Journal of the Florida Medical Association. It has been my privilege to be associated with The Journal for 30 years, all but three of them as Editor. I greatly appreciate the confidence you manifest in me by re-electing me to the editorship year after year. It is gratifying to know that I may have had some part in the great progress of our Journal.

Membership in our Association is rapidly increasing. Current figures show that the average monthly circulation of The Journal is 2,866. In March, 3,092 Journals were mailed. Of these, 2,627 went to members, and the remainder to individual subscribers, advertisers and exchanges. Subscriptions go to Australia, Canada, England and Germany. Requests for reprints of scientific articles and requests for exchange agreements with The Journal continue to come from all over the world.

Increase in publishing costs and price of paper stock has made it necessary to cut down greatly on the number of complimentary and exchange copies of The Journal being sent out.

Forty-seven scientific papers were published during the past fiscal year, of which 42 were by members. Fourteen of the papers published, nine by members and five by guest speakers, were read at the 1954 annual meeting in Hollywood. One of these, Dr. Samuel M. Day's article on "Extensive Surgery and Repeated Surgery for Malignant Disease," won the Duval County Medical Society prize for the best scientific paper by a member of the society published in 1954. This paper appeared in the December issue of The Journal.

The September Journal was captioned the "Medical Education Issue." The featured article was the address of Dr. Wilburt C. Davison, Dean of the Duke University School of Medicine, guest speaker at the 1954 convention in Hollywood, whose subject was "Changes in Medical Education and Patient Care." A section on "Medical Education in Florida" contained pictures and write-ups on Robert T. Spicer, M.D., Retiring Dean of the University of Miami School of Medicine; Homer F. Marsh, Ph.D., Dean of the University of Miami School of Medicine; and George T. Harrell Jr., M.D., Dean of the College of Medicine of the University of Florida. The programs for the two schools as outlined by their deans were also published. An editorial on "Making Doctors" completed the information on medical education in this interesting and informative issue of The Journal.

In November we published the "A.M.A. Clinical Session Issue." This number contained pictures and write-ups on the Eighth Annual Clinical Session of the American Medical Association, which was held in Miami, November 29-December 2.

We consider our editorial and commentary section outstanding in state medical journalism. We endeavor to keep these pages sufficiently diversified so that all members will find something of interest. Again this year the December Journal carried a seasonal editorial by Dr. Frank G. Slaughter, a member of our Association who is a distinguished author and Biblical authority. It was entitled "The Physician's Heritage."

The December, January, February and March issues contained a series of timely editorials on "The Malpractice Insurance Problem," written by Dr. Robert E. Zellner, Chairman of the Association's Committee on Medical Economics. Each month a different aspect of this problem was discussed. The concluding editorial offered a constructive plan for improving malpractice insurance experience in Florida.

During the past year 62 abstracts of articles published by our members in out-of-state medical journals were published in The Journal. These abstracts summarize many valuable contributions to medical literature made by Association members. The staff is constantly scanning other journals for articles written by our members. It is possible, however, that some papers may be missed. Members are therefore urged to send us reprints of their articles published in out-of-state medical journals.

Members are also urged to send in contributions for the State News Items and Component Society Notes columns. These two features are always of interest to the readers. Our sources of information include county society bulletins, newspaper clippings and information sent in by members and county societies. These two sections could be far more informative with more contributions from the members.

Of interest to many readers are sections on Florida Blue Shield, State Board of Health, Books Received, Births, Marriages and Deaths, Obituaries, Correspondence, Medical Licenses Granted and the Woman's Auxiliary. The Journal carries a list of Association officers and committee members, a schedule of meetings of certain medical organizations and a tabulation of county societies together with their presidents, secretaries, meeting dates and current membership.

A section on "Others Are Saying" was added just one year ago and has aroused much interest among our readers. This section contains timely items of interest taken from other medical publications.

I wish to express sincere appreciation to the Assistant Editors, Drs. Webster Merritt and Franz H. Stewart, and to the Associate Editors, Drs. Louis M. Orr, Joseph J. Lowenthal, Jere W. Annis, Herschel G. Cole, Wilson T. Sowder, Carlos P. Lamar and Walter C. Payne Sr.

The assistance of Drs. Chas. J. Collins and James N. Patterson, who have served with me on the Committee on Publication, has been invaluable. They have read and approved the scientific articles published in The Journal before they were referred to me. This service take time and effort which should merit the gratitude of the entire membership.

Dr. Kenneth A. Morris, Chairman, and his assistant, Dr. Walter C. Jones, are responsible for the smooth functioning of the Abstract Department. We are greatly indebted to them.

Many Journal authors have had occasion to utilize and appreciate the valuable talent of Mrs. Edith B. Hill, Editorial Consultant and Manuscript Editor. The Journal is fortunate to have on its staff a professional medical writer whose services cover all the refinements of medical journalism.

At this time I wish to express sincere appreciation to Mr. Ernest Gibson, Managing Editor, for able service to The Journal. Under his leadership The Journal not only has kept up its high standards but also has continued to make notable progress.

The detail work of getting The Journal ready for publication each month has been capably performed by Mrs. Blois B. Pearson, Journal Technician.

The Journal belongs to you, the members of the Florida Medical Association. It can be only as good as you make it. It is a reflection of the medical progress in the state and thus reflects the medical profession and each individual member of the Association. Suggestions and criticisms are always welcome. The Journal can be the kind of publication you want only if you let your desires be known.

Respectfully submitted,
Shaler Richardson, M.D., *Editor*

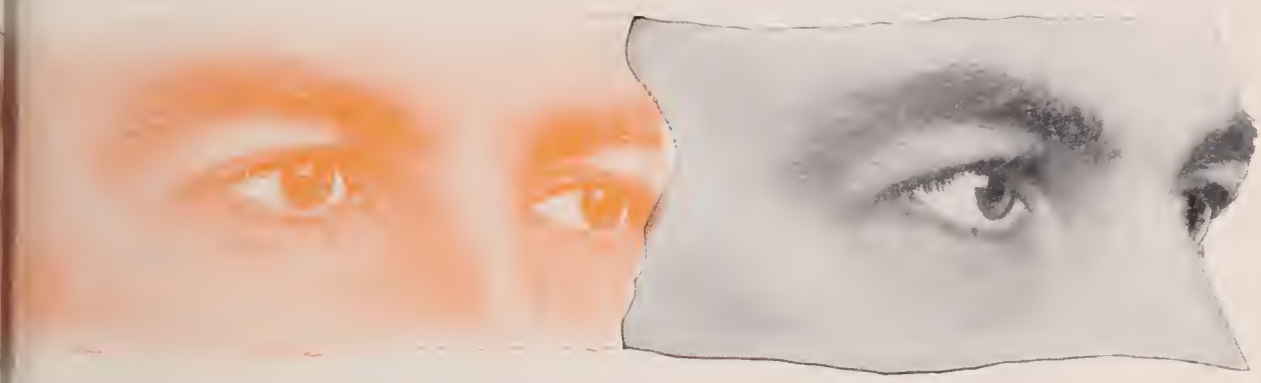
MORE AND MORE PHYSICIANS ARE TURNING T



ACHRO

WHEN A BROAD-SPECTRUM ANTIBIOTIC IS INDICATED

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Dr. John Dean Milton, the son of the Reverend James D. Milton, a Methodist minister and Juna Lively Milton, was born in Mountville, Georgia, on June 17, 1898.

In 1921 Dr. Milton received the degree of Bachelor of Science at Emory University in Atlanta, Georgia. Two years later he was awarded the degree of Doctor of Medicine from the Emory School of Medicine, serving his internship at Piedmont Hospital in Atlanta.

Coming to Miami in 1925, he was associated with Dr. Levitt in the practice of obstetrics and gynecology. From the very beginning our new president was active in medical circles in Miami and throughout the State. Through the years Dr. Milton has found time to serve his profession in manifold ways.

For six years he held internships and residencies and did post-graduate work at Lying-In-Hospital in New York City, the Cook County Post-Graduate School, and the University of Tennessee.

Dr. Milton's activities and achievements are numerous. He has served as President of the Medical Staff at Victoria Hospital, Miami 1934, Secretary of the Executive Medical Staff at Jackson Memorial Hospital in Miami 1939, Member of the Medical Staff at St. Francis and Mercy Hospitals, Miami, President of the Miami Obstetrical and Gynecological Society in 1951, Director of Obstetrics and Gynecology at Miami at Jackson Memorial Hospital from 1952 through the present time. He is now Professor and Chairman of the Department of Obstetrics and Gynecology at the University of Miami School of Medicine.

Dr. Milton enjoys association with the following sectional and national medical organizations: American Board of Obstetrics and Gynecology, Southern Medical Association, American Medical Association, American College of Surgeons, South Atlantic Association of Obstetricians and Gynecologists, Southeastern Surgical Congress, American Academy of Obstetrics and Gynecology, Miami Obstetrical and Gynecological Society, and Florida Obstetrical and Gynecological Society.

Medicine as an organization has benefited by Dr. Milton's contribution in many capacities, namely, Vice President of Dade County Medical Association, 1937 and 1947, President of DCMA

in 1949, Member of the Executive Committee of DCMA 1946 through 1949, Member of Board of Trustees of DCMA 1949 through 1954, Chairman FMA Economics Committee 1948, Chairman FMA Necrology Committee 1938, Chairman FMA Fee Schedule Committee 1950 through 1953, Chairman FMA Council 1953 and a member of the Board of Governors of FMA 1950 through 1953.

In addition to his busy professional life, Dr. Milton has been an asset to his community. At various times he has been a member of the Board of Directors of the Blood Bank of Dade County, a member of the City of Miami Long-Term Capital Improvement Budget Committee, President of Medical Service Bureau, Chairman Dade County Medical Division of Civil Defense, and Vice Chairman of Southeastern region, State of Florida.

Shortly after the beginning of World War II, Dr. Milton entered the U. S. Army Medical Corps as a Captain and was relieved of duty in 1946 with the rank of Colonel. He is now a member of the FMA Advisory Committee to Selective Service.

Dr. Milton is a member of the Trinity Methodist Church in Miami, Blue Lodge #247 Mason, Royal Order of Jesters, Scottish Rite Masonry, a Shriner, Mahi Temple, American Legion Post #29 and 40-8 Society of American Legion. When time permits he enjoys golf and his duties as a director of several business organizations.

Dr. Milton has two daughters, Mrs. Robert W. Paden of Albany, Georgia, and Mrs. Euell Whatley of Atlanta, Georgia. He is married to Mrs. Rheda Watson Milton. His associate in practice is his step-son Dr. Robert M. Watson, whose children add the grandparents' air to the Milton home.

PROCEEDINGS

EIGHTY-FIRST

ANNUAL MEETING

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Highlights of the Eighty-First Annual Meeting

The Proceedings published in this issue of The Journal cover in detail the constructive measures taken by the Association at the Annual Meeting held in St. Petersburg early in April. Particularly timely was the action of the House of Delegates in approving By-Law changes which made permanent the Committee on Mental Health. The duties of the committee are "to direct attention of members of the Association to affairs relating to the field of mental health, to make specific suggestions for action in the field of mental health, and to serve as liaison with other state organizations interested in mental health." Each county medical society is urged to establish a similar committee.

In his address at the convention Dr. Elmer Hess, then President-elect of the American Medical Association, commended this action and the constructive approach in Florida to this mounting problem. He spoke at some length on the magnitude of the perplexing mental health situation, pointing out that the states now spend $560,000,000 each year on the care of the mentaly ill and the federal government a slightly larger amount, while these patients lose a billion dollars a year in wages and the country loses three billion dollars a year in productivity. Yet, only $6,500,000 a year is spent in research on mental illness.

In view of the rapidly changing nursing situation, the inadequate supply of nurses and the frequency with which the advice of physicians is sought on nursing legislation, a resolution was presented and passed requesting the House to consider By-Law changes at the 1956 meeting which would establish a Committee on Nursing. Similar action was taken with regard to a Committee on Blood. This committee would function largely in an advisory capacity and provide appropriate liaison with Blood Bank and Civil Defense organizations.

Of particular interest was the action of the House in voting to request the American Medical Association to re-examine its policy concerning veterans with wartime service suffering from tuberculosis of nonservice origin on the basis of a survey indicating that existing civilian facilities may be adequate. In excepting these veterans when it specified the conditions of its objection to the admission of veterans to veterans administration facilities for treatment of non-service-connected disabilities, that organization was influenced by the shortage at the time of civilian facili-

ties for the care and treatment of this disease. Now that great strides have been made in its care and treatment through the discovery and increased use of antituberculosis drugs, thereby shortening the hospital stay and making additional beds available, a reappraisal of its position in the matter is asked on the basis of a survey of existing civilian facilities.

The recommendations of the Committee on Medical Economics, including the supplement on the Insurance Plan, met with the approval of the House. The Board of Governors was empowered to act for the Association in contracting with an insurance company to provide a group professional liability insurance plan to be made available to members of the Association. Also approved was the motion that the chairman of the Committee, Dr. Robert E. Zellner, and the Committee be commended for their good work.

The Committee on Medical Postgraduate Course, in a supplemental report adopted by the House, recommended that its function be expanded. It received permission to invite all interested groups within the state who plan formal courses in graduate medical education to submit their proposed programs at a reasonably advanced date to the Association's Committee for the purpose of coordination and integration of graduate medical activities throughout the state.

An innovation at the St. Petersburg meeting was integration of the programs of some of the specialty societies into the Association's scientific program. The Committee on Scientific Work invited the specialty groups to hold their meetings during the session of the Association instead of immediately prior to it, as in the past. Five societies accepted this invitation. Their meetings were held during the first two days of the Association meeting, and the talent of their guest speakers was utilized for the scientific assemblies. In addition, for the first time the programs of two of the specialty societies were scheduled on one of the scientific assemblies. A joint symposium by the Florida Pediatric Society and the Florida Obstetric and Gynecologic Society was presented during the third scientific assembly. The Committee on Scientific Work was instructed to evaluate this change.

A resolution was approved by the delegates commending Governor LeRoy Collins for his action in the study of the problem of indigent hospital care with recommendations to the legislature for its solution. Also endorsed and commended were efforts of the Florida Children's Commission and the Florida State Board of Health to obtain passage of legislation making mandatory proper identification of small containers of kerosene which are sold commercially. The importance of such a measure as a means of reducing the hazard of poisoning from this source, especially in children, was emphasized by a survey which showed that in 1953-1954 there were approximately 500 treated cases of poisoning from ingestion of kerosene with five fatalities in the state.

Dr. Herbert E. White of St. Augustine is the new chairman of the Association's Grievance Committee. He succeeds Dr. Walter C. Payne Sr. of Pensacola, who proposed and has headed the Committee since its inception. Dr. Payne was automatically retired since the Committee is composed of the last five living past presidents of the Association.

Dr. Rowland E. Wood of St. Petersburg succeeds Dr. James V. Freeman as chairman of the Committee on Emergency Medical Service. Dr. Freeman has been chairman of this Committee ever since it was formed.

There were 783 members in attendance at St. Petersburg, and the total registration was 1,665. The 1956 Annual Meeting will be held in Miami Beach with Hotel Fontainebleau as headquarters. The dates for this meeting have been set by the Board of Governors as May 13 to 16.

Convention Golf Tournament

The annual Florida Medical Association Golf Tournament was held this year at two St. Petersburg courses — Lakewood and Sunset. Lakewood was used by golfers competing for low gross prizes while low net score prizes were competed for on either course. Names of the winners were announced and prizes awarded at the Annual Dinner on Tuesday evening.

The Orlando Cup for low net score was won by Dr. Joseph L. Hundley of Orlando. Runner-up prizes were awarded to Dr. Karl T. Humes of Bushnell and Dr. James T. Shelden of Lakeland.

Dr. Curtis D. Benton Jr. of Fort Lauderdale was awarded the Duval Trophy for low gross score. Dr. Walter F. Davey of Stuart and Dr. A. Judson Graves of Jacksonville were runners-up.

Members of the Woman's Auxiliary to the Florida Medical Association held their annual tournament at the same time at Lakewood and Sunset courses.

The Orange County Trophy awarded this year for the first time went to Mrs. Harry L. Allan

Jr. of St. Petersburg, low gross scorer. Runner-up prizes were awarded to Mrs. William P. Farber of St. Petersburg and Mrs. Duncan T. McEwan of Orlando.

Winner of the Soreno Hotel Trophy for low net score was Mrs. Robert B. Mertz of St. Petersburg. Mrs. J. M. Ingram Jr. of Tampa and Mrs. Woodrow B. Estes of St. Petersburg were runners-up.

International Surgeons' Hall of Fame

Throughout the world the medical profession is manifesting great interest in the International Surgeons' Hall of Fame and Museum of Surgical Science.[1] This new institution, developing rapidly on Chicago's near north side, adjoins the headquarters of the International College of Surgeons, founded by Dr. Max Thorek. The idea of a surgeons' shrine and museum also originated with Dr. Thorek years ago, but his long-cherished hope was not realized until the trustees of the college acted in 1953 to establish the memorial. Work progressed rapidly and when the dedication ceremonies were held last September 9, much progress had been made. A distinguished Italian painter had completed sketches for the mural room depicting the development of surgical science through the ages, and many of the murals now have been completed. Life-sized figures of the immortals selected to occupy this room are being created by sculptors from the Chicago Art Institute. The 12 selected by an international committee of surgeons and medical historians are Imhotep, Hippocrates, Galen, Ambroise Paré, Vesalius, William Harvey, Giovanni Battista Morgagni, Ignaz Philipp Semmelweis, Louis Pasteur, Joseph Lister, Wilhelm von Roentgen, and Marie Curie.

Rooms in the Hall of Fame have been assigned to many countries or groups of countries. The countries that have already furnished rooms or partly so include Argentina, Austria, Brazil, British Commonwealth, China, Colombia, Egypt, France, Greece, Haiti, India, Israel, Italy, Japan, Mexico, Netherlands, Peru, Scandinavia, Switzerland, Turkey, United States and Venezuela. Others are to be added shortly. Among the priceless exhibits are the original postmortem report on the body of President Lincoln, the original mask used in administering the first anesthetic, 50 letters of Florence Nightingale, and the original model of the Carrel-Lindbergh artificial heart, which General Lindbergh himself installed in the Hall of Fame. In the Hall of Manuscripts there reposes Dr. Thorek's own remarkable collection of scientific papers, which will be greatly augmented by other persons and institutions interested in medical history.

On the lawn along Lake Shore Drive there has been erected a life-sized statue, dedicated only last February 10, which represents the surgeon rendering aid to a stricken patient. Sculptured by Edouard Chassaing, it is inscribed "Hope and Help" and "symbolizes the ideals of the International Surgeons' Hall of Fame and Museum of Surgical Science."[2] Yet to be realized is a plan for an amphitheater in the rear of the Hall of Fame where series of lectures by eminent speakers will be presented periodically to medical students, physicians, and the public.

Conceived to recognize the contributions of surgeons to freedom from suffering, to the prolongation of life, and to the progress of mankind, this unique institution has won at the outset a degree of cooperation and support from many nations and individuals that strongly indicates a genuine desire and need for continued progress. Delegates from 25 countries attended the dedication banquet last September. The Hall of Fame will be controlled by the international officers of the International College of Surgeons and by an electoral college of about 150 members, representing each section of the International College of Surgeons and each member nation in which no section exists. Nominations for the Hall of Fame are not restricted to member nations. Any surgeon in the world may suggest a nominee, but all nominees must have been deceased for at least 15 years. This shrine is a fitting memorial to those who have gone before — "another installment of our agelong debt to those who cleared the way for us, a debt to which we can never write 'paid in full'."[1]

1. The International Surgeons' Hall of Fame, J. A. M. A. 156:1586 (Dec. 25) 1954.
2. International Surgeons Dedicate Statue, J. A. M. A. 157:667 (Feb. 19) 1955.

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1954 Automobile Accident Toll

Come June and "sumer ys icumen in," in the words of an old English air. Vacation time is overtaking the nation, and a long weekend looms ahead next month with Independence Day falling on Monday. Millions look forward to Friday each week, for it promises a weekend of relaxation and pleasure, a break in workaday routine. A long weekend is especially welcome and means much extra travel, adding to the already far too high automobile accident toll. Weekend crashes accounted for 13,980 killed and 678,000 hurt during 1954.[1] Thirty-nine per cent of the deaths and 35 per cent of the injuries in the nation's automobile accident toll occurred last year on Saturdays and Sundays.

Traffic accident statistics are, at best, always grim. The 1954 record was some 35,500 persons killed and 1,960,000 injured. These figures represent a moderate decrease in injuries over the previous year and the first decrease in the death toll since 1949.

Again last year, speed was the most dangerous driving mistake, killing 12,380 and injuring more than 659,000. Three out of four automobile accidents happened to passenger cars being driven in clear weather on dry roads, and 78 per cent of the vehicles involved in fatal accidents were traveling straight ahead. Drivers under 25 years of age were involved in more than 24 per cent of last year's fatal accidents although they constitute only about 14 per cent of the total number of drivers. Three out of five deaths occurred during the hours of darkness. Ninety-five per cent of the vehicles involved were in good mechanical condition.

For the fourth consecutive year, the pedestrian record reflected improvement. The 7,700 pedestrian deaths for 1954 were almost a thousand less than for the preceding year. "Jay walking," crossing between intersections, remained the chief cause of pedestrian deaths and injuries.

Even with the slight improvement over the more than two million casualties reported in 1953, the traffic accident toll is staggering. State and community authorities have spent millions of dollars in an effort to provide safer and better roads and saner driving. Insurance companies and other private firms are spending millions for safety education. State, county, local and parkway police are constantly patrolling streets and highways. More and better engineered thruways are coming off the drawing boards. Newspaper, radio and television messages continually remind drivers to drive safely. Traffic regulations are set up as a proper guide for the handling of traffic. It seems that almost everyone is concerned with the needless highway slaughter and its accompanying waste of human life and property values — everyone, that is, except the driver. The basic ingredients of the bloody record are the motorist's carelessness, inaccuracy, and failure to exert mastery of mind over machine. Even 1954's Safe Driving Day, set by Presidential decree, resulted in a record not appreciably better than that of any other normal driving day. Furthermore, the Christmas weekend was the bloodiest in the nation's history.

True enough, the death rate has declined from 115.9 per 100,000 registered vehicles in 1941 to 61.1 in 1954, a decrease of almost 50 per cent. How proud the dead would be, if only they could read. Likewise, it is true that injuries decreased somewhat in 1954, but during the period from 1941 to 1954 injuries rose from 1,488,000 to 1,960,000 per year, an increase of 32 per cent. Except for modern medical technics, many of those injured would be among the dead. What a careful study of the statistics reveals is that the rate reductions have come about, not because of the drivers, but in spite of them. Excessive speed, failure to grant the right of way, and driving on the wrong side of the road constituted 75 per cent of the driving errors in 1954 which resulted in death and injury, a percentage not substantially different from the figures of previous years. The rate reduction, therefore, was due far more to mechanical and engineering improvements than to a fundamental change in driver attitude.

Obviously, neither gigantic publicity campaigns, nor improvements in highway engineering or automobile design can effect more than a token improvement in the grim results of the nation's traffic situation. The human element remains unchanged, and gradually even these benefits become fresh causes of disaster. While it is true that increased speed can provide a ready escape from danger, it is more likely to lead to catastrophe. While it is true that wider and straighter roads eliminate certain driving hazards, they are more likely to provide the setting for even greater peril. While it is true that improved brakes will stop a car quicker, it is more likely that the driver will become dangerously overconfident.

Manifestly, individual determination and skill and a cooperative spirit must be coupled with engineering progress if there is to be any dramatic

1. Misguided Missiles, The Travelers 1955 Book of Street and Highway Accident Data, The Travelers Insurance Companies, Hartford, Conn.

turn for the better. No matter how good the road or how mechanically perfect the car, it is the driver who can, in an instant of carelessness or complacency or while drinking, transform the road into a scene of carnage, and the automobile into a missile of destruction. If 1954's decline in highway fatalities, brought about by science and engineering, will be taken as a personal challenge by the drivers of the nation's 58,129,000 motor vehicles, through the constant exercise of care and good judgment the automobile can assume its rightful place as a means of safe, sure transportation.

The Public Attitude Toward the Doctor

What does Florida think of its doctors? How its citizens regard the physicians who serve them would be interesting to know. Are doctors in the public doghouse? Are they arrogant? Are they indifferent to patients' welfare? Do they charge too much? The public's answers to these questions might be as gratifying as they were in a far northern state.

Recently the Minneapolis Sunday Tribune set out to find the answers to these questions from the people of Minnesota. This enterprising newspaper, which has more than a half million circulation, conducted a survey that covered the entire state. On the whole, it found, people disagree vigorously with critics who lash out everlastingly at doctors.

According to the survey the medical profession of Minnesota is indeed well regarded:

Two thirds of the people considered physicians' fees reasonable.

More than four out of five were satisfied that doctors "take a personal interest in their patients and their troubles."

Most of them were confident that if they called a doctor to make a home visit, he would come.

Eighty-seven per cent believed physicians are better trained nowadays than they have ever been before.

Would Florida's well informed, cosmopolitan citizenry show a like attitude if a similar survey were made? Such a response would be gratifying, as it was in Minnesota.

Practical Nurse Study Begins

A study of the practical nurse program in Florida is being made under the direction of the Florida State Advisory Committee on Practical Nursing, which represents the Florida State Nurses Association, Florida State Board of Nurse Registration and Nursing Education, Florida State League of Nursing, Florida Hospital Association, Florida State Board of Health, Florida Licensed Practical Nurse Association, American Red Cross, Lay Public, and Florida State Department of Education.

This study of practical nursing is being made for four main reasons: (1) to determine the strengths and weaknesses of the present instructional program and point out areas which need particular emphasis; (2) to see how the program may better serve the purposes for which it was intended; (3) to determine the extent to which the practical nurse program should be developed in Florida; and (4) to determine the extent to which the trained practical nurse will be used by organized agencies if available.

The research details for the study are being coordinated by the Florida State Department of Education, Division of Vocational and Adult Education, through the Trade and Industrial Education Section, of which Mr. H. F. Hinton is State Supervisor and Miss Helen E. Shearston, R.N., is Coordinator of Practical Nursing. Mr. B. R. Tilley, Survey Specialist from the Division of Administration and Finance of the State Department of Education, is the research consultant for the study, and Mr. T. A. Backus, doctoral student at Florida State University, is a research assistant. Mrs. Caroline Langston is secretary for the project.

The study, which was made possible by a grant from the W. K. Kellogg Foundation, is expected to be completed about January 1956. Four other states, namely, Alabama, Arkansas, Louisiana and Mississippi, are making similar studies, and a composite regional report is expected to be made in the early spring of 1956. Copies of this report will be prepared for distribution wherever there is an interest in practical nursing.

Questions or comments concerning the Florida study may be addressed to the Trade and Industrial Section, Florida State Department of Education, Tallahassee.

Esophageal Speech Postgraduate Course Miami, June 13-July 1, 1955

A course in Esophageal Speech and Organic Voice Problems will be sponsored this month by the University of Miami School of Medicine. This unusual opportunity for postgraduate study is offered for speech therapists, otolaryngologists and rehabilitation specialists. The course begins on Monday, June 13, and continues for three weeks, ending on July 1.

This intensive course of postgraduate study, believed to be the first of this nature ever offered in this country, is a pilot program in which the government is greatly interested. It will be presented under the direction of Dr. Nathaniel M. Levin of Miami and his staff.

An M.A., Ph.D., or M.D. degree is required of registrants. Those in active teaching positions and others in universities, speech clinics and rehabilitation centers are eligible, and there will be several openings for Bachelors in Speech Pathology and rehabilitation counselors. The enrolment is limited, and the tuition fee is $150. Ten traineeships, which include tuition and traveling expenses and are valued at $250 each, will be available to qualified persons on application. Forms will be mailed on request.

Morning sessions will be held Monday through Friday during the entire period. The program will include a one hour period of clinical demonstrations, conferences or special lectures, followed by a two hour period of actual work in training technics with laryngectomized patients.

An outline of the course includes an introductory discussion of the problems of laryngectomized patients; hoarseness as related to differential diagnosis of benign and malignant lesions; organic voice disturbances, such as vocal nodules, contact ulcers, vocal cord paralysis, and sequelae of laryngofissure and other operative procedures; main aspects of cancer of the larynx; treatment of the malignant larynx, both surgery and/or roentgen therapy; total laryngectomy operation, alone or combined with radical neck dissection, with pharyngectomy and/or glossectomy, and tracheotomy; discussion of the altered status after laryngectomy, covering changes in anatomy and physiology and problems during the convalescent and readjustment periods; mechanism of esophageal speech, including comparison with the normal speech mechanism and characteristics of esophageal speech; esophageal speech training and rehabilitation, covering methods and technics and actual training technics with beginning and advanced students; and the artificial larynx, demonstrating several types of artificial devices, their uses and limitations.

Trained counselors will discuss vocational and social readjustment. Special lectures will be given by representatives from the Office of Vocational Rehabilitation, National and Regional, and from the U. S. Veterans Administration, and others. Round table discussions will deal with unusual experiences, clinical and training problems, and research problems. In addition, there will be numerous demonstrations including color slides, silent and sound motion pictures, recordings, models, presentation of patients, oral and laryngeal lesions, operative procedures, and postoperative results.

The course is being presented with the cooperation of the Office of Vocational Rehabilitation, Department of Health, Education, and Welfare; Florida and Regional Divisions of Vocational Rehabilitation, U. S. Veterans Administration; Florida Laryngectomees Association; and members of the Georgia and International Association of Laryngectomees.

An associated feature will be the Convention of the International Association of Laryngectomees, to be held in Miami during the last week in June. Laryngectomees from all over the United States and Canada will assemble there for this meeting. Some have not yet learned to talk and will attend speech classes as trainees.

For information, address all communications to Elaine Bulmer, RN, Secretary, 1431 North Bayshore Drive, Miami.

PRESIDENT McEWAN'S
ADDRESS
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Incidence of Poliomyelitis by Age, Race, and Sex (For Use in Determining Priorities for Administering Salk Poliomyelitis Vaccine)

The following is a summary of information concerning the incidence of poliomyelitis by age, race, and sex. This information should be used in determining priorities for administering Salk Poliomyelitis Vaccine. The report is based on an analysis of cases reported in Florida for the years 1946 to 1954 and thus includes two epidemic years and the span between them.

AGE AND RACE. Poliomyelitis cases have been reported in infants as young as 1 month of age. Beginning at birth the incidence builds up with increasing age, reaching a peak in the white race at age 5. The average annual rate for whites under 1 year of age during the period 1946-1954 was 45.2 per 100,000. Children aged 7 to 11 months had a case rate which was as high as for the 1 year old group. The peak rate at 5 years of age was 84.8 and the rate did not fall below the initial under-one-year age level until age 11 when a rate of 44.8 per 100,000 was noted. After age 11 the rates fall off to a low of 18.2 at age 18, rise again in the twenties and diminish steadily thereafter.

At all ages, the rate for Negroes was considerably below the white rate for the corresponding age. Negro rates reached a maximum of 44.2 per 100,000 at age 1 and fell rapidly thereafter.

SEX. At most ages, other than the child-bearing years, white female rates were below the rates of white males. In the age bracket 15-34, white female rates exceeded white males. Among Negroes in this age group, rates are small and fluctuate considerably, and no definite pattern is evident. The higher rate among white females in this age group is believed to result from a greater susceptibility of pregnant women to the disease.

Detailed data are shown in tables 1 and 2 and in figure 1. Also shown is an estimated production schedule of poliomyelitis vaccine from data supplied by the six licensed manufacturers to the U. S. Department of Health, Education and Welfare (table 3).

The recent conference in Washington recommended that first priority should be given to children aged 1 through 9.

Wilson T. Sowder, M.D.

Table 1. — Reported Cases of Poliomyelitis Per 100,000 Population by Five Year Age Groups, by Race, and Sex, Florida, Average for Period 1946-1954

AGE (IN YEARS)	WHITE		NON-WHITE	
	MALE	FEMALE	MALE	FEMALE
0-4	74.7	57.4	38.2	22.3
5-9	88.4	53.3	13.9	15.8
10-14	49.2	37.8	7.1	4.7
15-19	23.3	25.9	3.1	5.4
20-24	15.8	29.4	3.4	2.9
25-29	21.2	27.6	2.5	2.6
30-34	14.0	14.1	3.2	1.6
35-39	7.9	6.3	0.9	0.4
40-44	2.9	2.4	0.9	—
45-49	1.5	1.6	1.0	—
50-54	0.3	0.6	—	0.7

Table 2. — Reported Cases of Poliomyelitis per 100,000 Population by Single Years of Age for Children Under 12 Years of Age and by Months Under One Year of Age, by Race, Florida, Average for Period 1946-1954

AGE	WHITE	NON-WHITE
In Months		
0-1	11.9	—
2-3	25.2	14.6
4-5	26.7	7.4
6-7	44.5	37.0
8-9	65.2	25.9
10-11	72.6	29.6
In Years		
Under 1	45.2	21.4
1	62.2	44.2
2	71.6	36.2
3	69.9	27.7
4	81.1	20.5
5	84.8	23.2
6	77.1	19.5
7	71.4	9.6
8	62.8	14.2
9	52.7	6.7
10	57.7	7.2
11	44.8	6.1

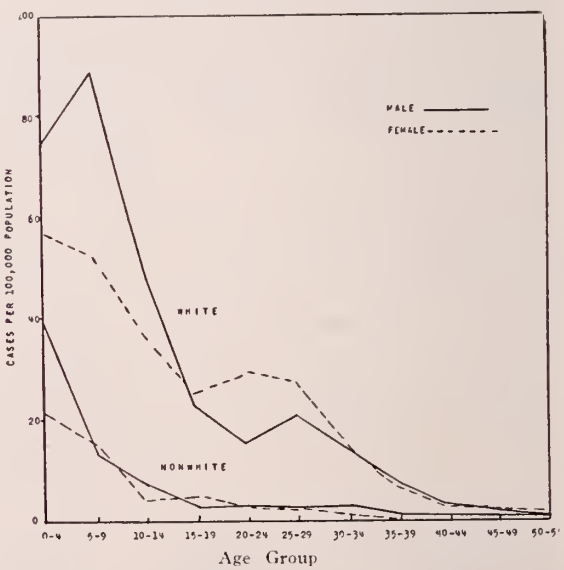


Fig. 1. — Reported Cases of Poliomyelitis per 100,000 Population by Age, Race, and Sex, Florida, Average for Period 1946-1954.

Table 3. — Estimated Cumulative Production of Poliomyelitis Vaccine From Data Supplied by the Six Licensed Manufacturers to U. S. Department of Health, Education, and Welfare

	Estimated Production Through Date Specified (in millions of cubic centimeters)			Equivalent Immunizations at 2 cc. each		
	For NFIP Contract	For Commercial Sale	Total	Number	This could immunize the following percentage of children in the following age groups	
					1-9	1-19
April 20, 1955	7.4	— *	7.4	3,700,000	11.0	6.7
May 1	17.0	.2	17.2	8,600,000	25.5	15.6
June 1	18.0	14.1	32.1	16,050,000	47.5	29.2
July 1	18.0	33.3	51.3	25,650,000	75.9	46.7
Aug. 1	18.0	51.3	69.3	34,650,000	over 100	63.0
Sept. 1	18.0	65.1	83.1	41,550,000	"	75.6
Oct. 1	18.0	78.9	96.9	48,450,000	"	88.1
Nov. 1	18.0	93.4	111.4	55,700,000	"	over 100
Dec. 1	18.0	107.9	125.9	62,950,000	"	"
Jan. 1	18.0	122.3	140.3	70,150,000	"	"

*Quantity small and unknown.

Graduate Medical Education
Short Course, June 20-24
Special Dinner, June 22

The Committee on Medical Postgraduate Course of the Florida Medical Association and the Department of Medicine of the Graduate School of the University of Florida announce with regret that because of an acute illness Dr. E. C. Hamblen of Duke University School of Medicine will be unable to carry out his assignment to give the lectures on Gynecology at the Short Course on June 23-24. Replacing Dr. Hamblen will be Dr. Leonard Palumbo, Assistant Professor of Obstetrics and Gynecology at the University of North Carolina School of Medicine. This substitution necessitates a complete change in the lectures on Gynecology as published in the Short Course schedule in the May Journal. The subjects of Dr. Palumbo's lectures with the summaries are as follows:

1. The Diagnosis and Treatment of Pelvic Malignant Disease
   This paper includes a discussion of the general problems of genital malignant disease, emphasizing prevalent methods of diagnosis and current concepts of therapy.
2. Diagnosis and Treatment of Vulvovaginal Lesions and Pruritus Vulvae
   The routine employment of certain diagnostic tests which can be employed in clinics or office practice has increased the accuracy of the diagnosis of various vulvovaginal lesions. The diagnosis and treatment of these lesions and the general problems of pruritus vulvae are reviewed.
3. Uterine Bleeding Due to Nonmalignant Causes
   Abnormal uterine bleeding is one of the most common of all pelvic complaints. This paper covers the discussion of uterine bleeding due to nonmalignant causes with regard to etiology, incidence and management.
4. Exfoliative Cytology in Gynecologic Practice
   An attempt is made to evaluate the place of cytology in gynecology with a discussion of the values and limitation of cytology as a cancer detection technic as well as other information which can be derived from the careful study of the cytologic smear.
5. The Place of Radical Hysterectomy in the Management of Carcinoma of the Cervix
   The renascence of the surgical management of carcinoma of the cervix in the past decade has revived the old controversy as to whether irradiation or surgery constitutes a better method of treatment. An attempt is made to evaluate the present status of radical hysterectomy including possible indications, complications, and results.

Dr. Palumbo is widely recognized as an excellent teacher in his particular field.

On Wednesday evening, June 22, there will be an informal dinner on the Mayflower Hotel Roof. The President of the University of Florida, Dr. J. Wayne Reitz, will be the principal speaker at the dinner and will discuss "The Relation of Medical Education to the Graduate Program of the University." In addition to Dr. Reitz's address, there will be brief talks by Dr. Russell Poor, Provost for the J. Hillis Miller Health Center, and Dr. George T. Harrell Jr., Dean of the College of Medicine of the University of Florida, on graduate medical education in Florida. Invited guests include the President of the Florida Medical Association, Dr. John D. Milton, the President-elect, Dr. Francis H. Langley, and the Immediate Past President, Dr. Duncan T. McEwan, as well as other members of the Association.

It is hoped that all physicians registered for the Short Course will attend this dinner. Any member of the Florida Medical Association, even though not registered, will be most welcome to attend. Dinner tickets are $5 and may be secured at the registration desk during the Short Course, or reservations may be made by mail. All reservations must be made by the morning of June 22.

Psychiatry Seminar Precedes Short Course

The Seminar on Psychiatry begins on Thursday, June 16, and will last until noon on Saturday, June 18. As announced in the May Journal, there will be two public meetings. The Thursday evening meeting will be on the subject of child guidance while that on Friday evening will stress alcoholism. Programs will be mailed to all physicians in the state. The registration fee for this course will be $10.

OTHERS ARE SAYING

The Decline of the House Call

Once the standard symbol of the medical practitioner, the little black bag seems headed for a museum. The house call is coming to account for less and less of the doctors' practice. The horse and buggy doctor would have included the maintenance of both the horse and buggy in his income tax deduction if they had income tax in those days. Making calls was a large part of his practice.

Now that transportation has become swifter, the doctor's need for it has become less. Some physicians practically never make house calls. Others do so with great reluctance and impose on the patient such discouraging obstacles as higher fees and tardy arrivals.

The reasons for this reluctance to make house calls are that the doctor is too busy, that equipment in the office is better or that the patient is not as sick as he thinks. This is quite in line with the trend of the times. Probably nothing that can be said or done now will reverse the trend. However before the house call becomes completely extinct we would like to utter this requiem.

There is nothing quite as challenging as a closed door. The doctor who has never waited for the door to open has lost out on one of life's interesting experiences. With today's modern diagnostic equipment it is much easier than it used to be to make a diagnosis. But in the home, the doctor must make a diagnosis with only the simple equipment he can carry in the bag plus his eyes, his ears, his fingers, his medical training and, one hopes, his God-given common sense. If he can do that, he is really playing in medicine's major league!

A patient sends for a doctor only when he considers himself in trouble. The doctor who responds is viewed as a friend in deed. Many harsh things have been said about medical practitioners during the last two decades. But no one ever says them about the doctor who is willing to reply to a cry for help by making a call to the home. Such a call may be time taking, economically profitless and subject to certain technical and scientific deficiencies. It is a cheerful symbol of service to people in trouble — a service which is the glory and the touchstone of our creed.

—The Journal of the Indiana State Medical Association, March 1955

The New Bigotry

Practically everybody considers himself a "liberal" and practically every liberal condemns bigotry and prejudice. This phrase, "bigotry and prejudice," one must assume, refers to a general condemnation of an entire class based on a preconviction that the group is inherently evil. And no liberal would be caught entertaining any such "prejudgments." Not against any ethnic or religious group that is. But there is one field where the liberal may be prejudiced to his heart's content. That is in distrusting physicians. Here he may accept as an article of faith, the thesis that physicians are inherently greedy and that all their opinions and actions are based on self-interest in the most unenlightened sense of that term. Indeed, it is even "smart" for the liberal to cling to such notions. Typically, he will reject the possibility that physicians, individually or in groups, are motivated by any honest dedication to public welfare.

If the doctor for himself or as spokesman for a medical society — if the doctor says that compulsory health insurance leads to second rate medical care, the prejudged answer snaps back: the doctor says that because he is prosperous under this system and doesn't want to reduce his income. If it is pointed out that the destruction of free choice removes something fine (and something therapeutically useful), the answer is that this is a myth dreamed up by physicians to protect their own interests. Indeed, the "liberal" in such a context will not even concede that the physician might be honestly mistaken in his attitude. He will have it that the doctor takes his position out of greed, and deny that any physician who opposes expanding health insurance could possibly be honorably motivated. If you point out that physicians are forever doing things against their own interests, you get laughed at. If you dare mention the vast amount of gratis work done by every M.D., you are told that this is being patronizing, or that this is simply the result of a bad conscience. If you repeat stories of personal devotion, hours of unremitting and unrewarded vigil, or of personal exposure, you are told that this is pure corn.

No example of heroism, sacrifice, or selfless dedication to patients, will make any difference. For the critic has already made up his mind. He has judged — indeed he has prejudged. And in the purest sense of the word, this is "prejudice." But it is the new prejudice, the permitted prejudice, even perhaps the fashionable prejudice. It is, furthermore, the safe prejudice, for the critics can be sure that no matter how hostile their tone, how unfair their condemnation, there can be no retaliation. For medicine's indispensable benefits are for friend and foe alike.

—The Journal of the Medical Society of New Jersey, February 1955

The Doctor, A Citizen

The letters "M.D." after our names do not exempt us from the citizen's responsibilities. On the contrary, a glance at 2,500 years of medical history will show that when the doctor is responsible to the whole community, he is most responsible to his primary obligation, the health and healing of his patient.

Only when we see our obligation to the patient as part of a prior responsibility to our fellow men can we maintain the integrity of Medical Ethics. Responsibility to community and responsibility to patient are not separate, conflicting claims, but parts of a whole, and neither obligation can be discharged apart from the other. . . .

A profession that furnished six of the fifty-nine signers of the Declaration of Independence cannot afford to neglect political responsibility when the very essence of democratic government is threatened at home and abroad. We ought not to let the "M.D." after our names disenfranchise us as voters and active participants in political organizations. *A. M. Phillips, M.D., in Southern Medical Journal.*

—The West Virginia Medical Journal, April 1955

(Continued from page 1054)

Exhibit "C"
Dues and Entrance Fees Collected March 21, 1954, Through March 19, 1955

NAME OF SOCIETY	TOTAL MEMBERS	NO. PAID MEMBERS	NO. IN ARREARS	1955 DUES COLLECTED	BACK DUES COLLECTED	ENTRANCE FEES
Alachua	56	47	9	1,560.00	240.00	70.00
Bay	26	21	5	680.00	80.00	
Brevard	27	5	22		440.00	
Broward	120	95	25	3,440.00	960.00	160.00
Columbia	11	11	0	280.00		
Dade	704	473	231	16,920.00	10,840.00	630.00
DeSoto-Hardee-Highlands-Glades	27	23	4	720.00	160.00	10.00
Duval	290	40	250		4,680.00	350.00
Escambia	107	92	15	3,200.00	560.00	160.00
Franklin-Gulf	7	7	0	240.00	80.00	
Hillsborough	184	143	41	5,080.00	2,120.00	110.00
Indian River	11	10	1	280.00	40.00	10.00
Jackson-Calhoun	17	17	0	600.00	120.00	
Lake	30	23	7	720.00	960.00	20.00
Lee-Charlotte-Collier-Hendry	39	36	3	1,320.	120.00	30.00
Leon-Gadsden-Liberty-Wakulla-Jefferson	67	60	7	2,040.00	720.00	150.00
Madison	6	4	2	120.00		10.00
Manatee	28	21	7	720.00	160.00	60.00
Marion	30	15	15	400.00	400.00	20.00
Monroe	13	9	4	280.00	40.00	20.00
Nassau	11	11	0	320.00	200.00	
Orange	192	147	45	5,440.00	1,040.00	200.00
Palm Beach	141	126	15	4,680.00	480.00	110.00
Pasco-Hernando-Citrus	17	16	1	480.00	40.00	10.00
Pinellas	227	217	10	7,720.00	960.00	280.00
Polk	99	91	8	3,120.00	2,960.00	100.00
Putnam	10	9	1	280.00	40.00	10.00
St. Johns	21	21	0	720.00		20.00
St. Lucie-Okeechobee-Martin	22	17	5	520.00	360.00	80.00
Sarasota	59	48	11	1,720.00	280.00	80.00
Seminole	20	19	1	680.00	40.00	10.00
Suwannee	9	3	6		120.00	
Taylor	4	1	3		80.00	
Volusia	86	54	32	1,800.00	480.00	70.00
Walton-Okaloosa	20	20	0	600.00	120.00	30.00
Washington-Holmes	5	4	1	80.00		
Totals	2,743	1,956	787	66,760.00	29,920.00	2,810.00

Dues not Payable		29,920.00	Back Dues Collected
Co. Soc. Secys. 35			
Life 103		96,680.00	Total Dues Collected
Excused 32		2,810.00	Entrance Fees Collected
Honorary 74			
Military Serv. 43	287		
Paying Dues	1,669	99,490.00	Dues and Entrance Fees

CORRESPONDENCE

Thanks From the Woman's Auxiliary

Dear Dr. Day:

I want to thank the members of Florida Medical Association for their fine cooperation during the 1954-55 year with their Auxiliary and with me, personally.

I particularly want to commend Mr. Ernest Gibson, Mr. Harold Parham and Mr. Tom Jarvis of the staff, who, throughout the year, showed all cooperation and courtesy to me. I wish to thank them and the Board of Governors, too, for the excellent provision made for the Auxiliary. The Soreno Hotel extended every courtesy and warm hospitality. The hotel personnel and staff did such a fine job it makes one want to return there.

If the cooperation we received this year continues, there is every reason to believe that the medical association can become increasingly proud of the work done by its Auxiliary.

With best wishes for the continued success of the state association, I am,

Most cordially,
Ann Spears Stover
(Mrs. Richard S.)

Medical Officers Returned

Dr. Charles N. Stevens, who entered military service on July 5, 1952, was released from active duty on July 4, 1954 with the rank of first lieutenant, U. S. Army. His address is 510 W. Tennessee St., Tallahassee.

Dr. Lawrence A. Toto, who entered military service on Feb. 9, 1953, was released from active duty on Feb. 8, 1955 with the rank of captain, U. S. Army. His address is 10605 N. E. 2nd Ave., Miami Shores.

Dr. Paul H. Jahn, who entered military service on Nov. 14, 1952, was released from active duty on Nov. 15, 1954 with the rank of captain in the U.S. Army. His address is 400 N. First St., Winter Haven.

Dr. James A. Poyner, who entered military service on April 20, 1953, was released from active duty on April 19, 1955 with the rank of captain in the U.S. Air Force. His address is Box 961, Panama City.

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. Roy M. Baker of Jacksonville announce the birth of a son, Dean Mitchell, on March 21, 1955.

Dr. and Mrs. John M. Schultz of Miami announce the birth of a son, Steven Edward, on March 27, 1955.

Marriages

Dr. Samuel Kaplan of Miami and Miss Helene De Baedts were married on March 25, 1955, in Miami.

Deaths — Members

Lawson, Ben Hill, Winter Garden	March 28, 1955
Kollar, Joseph B., Vero Beach	April 8, 1955
Stitt, Richard M., St. Petersburg	April 13, 1955
Miller, Alice R., Palm Beach	May 2, 1955

Deaths — Other Doctors

Parker, John S., St. Petersburg	Jan. 22, 1955
Cline, Daniel E., Pensacola	March 6, 1955
Young, Calvin T., Plant City	March 27, 1955
Gallagher, John F., Delray Beach	March 29, 1955
Newton, Robley D., Fort Myers	April 4, 1955
McMullen, D. Byrd, Clearwater	April 20, 1955

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Ayre, J. Ernest, Miami
Biel, Eugene E., Bradenton
Clark, Dorothy T., Winter Park
Colston, Nathaniel (Col.), Miami
Davis, David K., St. Petersburg
DiLorenzo, Ernest E., Dundee
DuBose, Howard M., Lakeland
Gunn, Samuel A., Surfside
Hall, Irving E. Jr., Bradenton
Harrison, Lloyd B. Jr., Panama City
Hastings, Lawrence V., South Miami
Healy, Raymond W., North Miami Beach
Howard, Karen, Miami
Jiminez, Manuel E., Miami
Johnson, Melvin J. Jr., Orlando
Mead, Charles A. Jr., Jacksonville
Parrish, Carroll E., Miami Springs
Perry, Benton B., Miami
Reiswig, Richard V., Jacksonville
Rubin, Seymour W., Miami
Sapp, Edwin E., Jacksonville
Scarlett, Joseph J., Key West
Tasche, John A., Sarasota
Toth, Alexander G. Jr., Miami
Van Schaick, Harold D., Miami Beach
Waring, Nell P. W., Jacksonville
Waring, William W., Jacksonville
Weil, Marvin L., Miami Beach

STATE NEWS ITEMS

Dr. Alfred E. Cronkite of Fort Lauderdale has been awarded a research fellowship by the American Cancer Society for study in exfoliative cytology. The program will be conducted from July 20 to September 19 at the University of California Medical Center.

Dr. Chas. J. Collins of Orlando has been appointed to the State Board of Health to succeed the late Dr. Albert L. Ward of Port St. Joe. The appointment was made by Governor LeRoy Collins.

Dr. Walter E. Murphree of Gainesville was recently sworn in as a new member of the City Commission of that city.

At the annual meeting of the Leon County Tuberculosis Association March 25, Dr. Joseph M. Bistowish of Tallahassee spoke on the problems of tuberculosis in Leon County. Dr. Clarence M. Sharp of Jacksonville spoke on some of the case-finding problems in Florida.

Dr. E. Sterling Nichol of Miami spoke on "The Problem of Coronary Thrombosis" at the Miami Heart Institute March 21.

Dr. Gerard E. Christie of Titusville was honored by selection as Titusville "Citizen of the Month" for February.

Dr. John H. Mickley of Hollywood was recently presented a scroll by the Chief of Police of that city for "being a person in the community who has made an outstanding contribution to law enforcement."

Dr. Frank G. Slaughter of Jacksonville spoke on "Facts Into Fiction" at the Miami Public Library on March 17.

Dr. John R. Emlet of Pensacola spoke on cancer at a luncheon meeting of the Kiwanis Club of that city March 29.

Dr. John W. Vaughn of Lakeland has returned to his practice after attending the Emory Clinic meetings.

Dr. H. Philip Hampton of Tampa has been elected to the board of Ye Mystic Krewe of Gasparilla.

At a national meeting of the Phi Lambda Kappa medical fraternity which was held in Miami Beach in March, Dr. Louis Lemberg spoke on "The Diagnosis and Treatment of Rheumatic Fever;" Dr. Bernhard Baer spoke on "Cellular Mechanism of Bacterial Resistance;" Dr. Charles Rosenfeld presented a film discussion on "Nephrosis;" Dr. Milton B. Jacobson gave a talk on "Urologic Diagnosis," and Dr. Samuel Gertman presented a paper on "The Internist's Viewpoint of Surgical Risk in the Aged."

Dr. Wesley W. Wilson of Tampa spoke March 31 before the Interbay Rotary Club on his method of treating an ulcerating type of children's birthmark.

Dr. Sidney Davidson of Lake Worth spoke on heart disease before the Rotary Club of Boynton Beach March 24.

Dr. John F. Lovejoy of Jacksonville has returned to his practice after attending the meeting of the International College of Surgeons in Geneva, Switzerland.

Dr. James N. Patterson of Tampa conducted the exams for the American Board of Pathology in Houston, Texas in April.

Dr. Ashbel C. Williams of Jacksonville was guest speaker at a meeting of the Woman's Auxiliary, St. Mark's Episcopal Church, March 7. His subject was "Cancer."

Dr. Cornelius S. Franckle of St. Petersburg spoke on cancer at a meeting of the Kiwanis Club March 8.

Dr. Walter C. Payne Sr. of Pensacola, on behalf of the Jackson Hospital Board of Trustees, presented a painting of the late Dr. Daniel A. MacKinnon to the hospital. The unveiling took place on March 10 in the lobby of the hospital of which Dr. MacKinnon was the first chief of staff.

Dr. Walter H. Winchester of Dunedin was elected president of the Rotary Club March 10.

Dr. John M. Packard of Pensacola preached the sermon during the evening service at St. John's Episcopal Church, Warrington, March 13. His subject was "Christian Vocation."

Dr. William K. Smith of Clermont spoke on cancer at a meeting of the Clermont Junior Woman's Club March 21.

During the annual convention at St. Petersburg, a pair of tri-focal glasses were left at the Florida Medical Association's registration desk in the lobby of the Vinoy Park Hotel. The owner may obtain the glasses by contacting the Association's office at P.O. Box 1018, Jacksonville.

All persons who desire a place on the lecture program at the Boston Clinical Meeting of the American Medical Association are urged to communicate immediately with the Chairman of the Program Committee, Theodore L. Badger, M.D., c/o Massachusetts Medical Society, 22 The Fenway, Boston 15.

Applications for space in the Scientific Exhibit are now available and will be sent on request. Exhibits will supplement the lectures as far as possible, and should portray subjects of a broad general interest. Requests for application should be sent to the Secretary, Council on Scientific Assembly, American Medical Association, 535 North Dearborn St., Chicago 10.

Dr. Wm. E. Van Landingham of West Palm Beach was presented a "Certificate of Appreciation" by Dr. Alvin E. Murphy of Palm Beach, president of the Florida Heart Association, "in recognition of outstanding voluntary service which has advanced the fight against heart diseases." The presentation was made on behalf of the Palm Beach County Heart Association at its annual meeting March 24.

Dr. Solomon D. Klotz of Orlando spoke before the meeting of the Southeastern Allergy Association which was held in Orlando in March.

Dr. Clarence M. Sharp of Jacksonville was speaker March 22 at a workshop for registered nurses held at the Southeastern Florida Tuberculosis Hospital. Dr. Sharp spoke on "Trends in Tuberculosis Control."

Dr. Edward W. Wood of Lake Worth has been appointed medical director for the Upholsterers International Union Health and Welfare Village at Jupiter.

Dr. Samuel Gertman of Miami spoke on "Medicine After Forty" March 23 at the Y.M.C.A. as the second in a series of talks on "Job-Success After 40."

Dr. Harold W. Johnston of Orlando spoke March 28 at a meeting of the Colonialtown Grandmother's Club.

Dr. Robert J. Boucek of North Miami Beach spoke on "The Treatment and Diagnosis of High Blood Pressure" March 28 at the Miami Heart Institute.

Dr. Stanley Frehling of Miami Beach was co-chairman of a dinner on behalf of Brandeis University held on March 31 at the Delano Hotel, Miami Beach.

Drs. James A. Winslow Jr., Leffie M. Carlton Jr., West B. Magnon, Roy F. Saxon Jr., Victor H. Knight Jr. and Kenneth G. Gould of Tampa were on the lecture staff of a session on the newest methods of nursing care for cardiac victims, held at the Southwest Florida Tuberculosis Hospital March 11.

At the meeting of the Florida Heart Association in St. Petersburg on April 2, Drs. Elwyn Evans of Orlando, John S. Bracken of Sarasota, Gaetano C. Ferrante of Tampa, William R. Tench of Clearwater, David S. Hubbell of St. Petersburg and Addison L. Messer of St. Petersburg presented papers. Dr. William P. Hixon of Pensacola moderated a panel on "Stroke." Participants included Drs. George T. Harrell Jr., Gainesville; Franz H. Stewart, Miami; J. Cornall Howarth, Orlando; and C. MacKenzie Brown, Tampa.

Dr. Meredith F. Campbell of Miami spoke before the Silver Jubilee meeting of the Southeastern Surgical Congress in February in Atlanta. His subject was "Ureterosigmoidostomy: Its Advances During the Past 25 Years."

Dr. J. Paul Chapin of Tallahassee has returned to his practice after taking postgraduate work at New York University-Bellevue Medical Center.

Dr. Peritz Scheinberg of Miami spoke at a meeting of the Greater Miami Multiple Sclerosis Society on April 17.

Dr. Hugh A. Carithers of Jacksonville was guest speaker at the regular monthly meeting of the Jacksonville Beach Junior Woman's Club on April 14.

Dr. Joseph M. Bistowish of Tallahassee was one of the nominees for the Criss Award which is presented to the individual or individuals who has made the greatest contribution to public health and safety during the year. Dr. Bistowish was nominated by the Tallahassee Jaycees.

Dr. Homer L. Pearson Jr. of Miami spoke at a luncheon meeting of the Miami Acacia Club on April 15.

Dr. Edwin C. Hanson of Belleview was honored on April 24 by the communities of Lake Weir. The appreciation day was sponsored by church and civic organizations and was held on the shore of Lake Lillian in Belleview.

Dr. Phillip W. Horn spoke on "What is TB?" and Dr. Clarence M. Sharp spoke on "Case Finding in Florida" before a group of 13 visiting students from the School of Social Welfare at Florida State University in Tallahassee. The program was held at the Tuberculosis Association of Duval County in Jacksonville. Drs. Augustus E. Anderson Jr. and Thomas H. Lipscomb gave a description of medical conferences necessary before a patient goes to a state tuberculosis hospital.

Dr. DeWitt C. Daughtry of Miami has returned to his practice after completing a course in pulmonary function in Boston.

The annual meeting of the Louisiana Heart Association will be held in the Louisiana State University Medical School Auditorium in New Orleans on June 16. The scientific session will be at 2:00 p.m., and the first annual assembly of Louisiana Heart Association members will take place at 4:00. At 8:00 p.m. a public forum on heart disease will be held.

Dr. Samuel M. Day of Jacksonville has been presented the Dr. John A. Beals Award for the most worthy scientific paper published by a member of the Duval County Medical Society during 1954. Entitled "Extensive Surgery and Repeated Surgery for Malignant Disease," the paper was published in the December issue of The Journal.

Dr. Reuben B. Chrisman of Miami, delegate to the American Medical Association and a member of the AMA Committee on Legislation, was in Washington April 29 where he testified before the House Armed Services Committee on proposed legislation of interest to the medical profession.

Members of the new temporary Committee on Nursing set up by the House of Delegates at the recent annual meeting are Drs. Jere W. Annis, chairman, Lakeland; Herbert L. Bryans, Pensacola; Thomas C. Kenaston, Cocoa; Norval M. Marr, St. Petersburg; and Lloyd J. Netto, West Palm Beach.

Dr. Bernard J. McCloskey of Jacksonville has returned to his practice after attending the meeting of the American College of Allergists in Chicago in April.

Dr. Samuel W. Page Jr. of Miami attended a course sponsored by the American College of Physicians at Cornell Medical College in New York in March. Subject of the course conducted by Dr. Irving Wright and his assistants was "Diseases of the Blood Vessels and Problems of Thromboembolism."

Dr. Lawrence E. Geeslin of Jacksonville took a graduate course under the auspices of the American College of Physicians at the Crile Clinic in Cleveland in March.

Dr. Floyd K. Hurt of Jacksonville attended a national meeting of Blue Shield in Chicago in March.

Drs. John J. Fisher, Paul F. Hutchins and Cornelia M. Carithers of Jacksonville were reelected to the executive board of the Duval County Chapter, National Foundation for Infantile Paralysis at the annual meeting of the chapter. Drs. Eugene M. Frame, Vernon T. Grizzard Jr., Bernard L. N. Morgan, Matthew E. Morrow Jr. and J. Q. U. Thompson were named to the medical advisory board.

Dr. Ray O. Edwards Jr. of Jacksonville spoke on "Communicable Diseases" before the April meeting of the Jacksonville Beach Junior Woman's Club.

Dr. Phillip W. Horn of Jacksonville took a postgraduate course in Pulmonary Diseases at Boston City Hospital in March. The course was sponsored by the American College of Physicians.

Dr. John H. Mitchell of Jacksonville has returned to his practice after taking a two week refresher course in fractures and traumatic surgery at Cook County Hospital in March.

Dr. Leo L. Nastasi of Miami entered medical service with the U. S. Navy on April 7, 1955.

Dr. Mariano C. Caballero of Miami entered medical service with the U. S. Army on May 7, 1955, with the rank of major.

Doctor's Day was observed throughout Florida on March 30. Governor LeRoy Collins issued a proclamation calling upon "all citizens of Florida to remember their physicians on that day and in some way express their appreciation to these guardians of the nation's health."

To mark the day in honor of their husband-doctors, members of Woman's Auxiliaries throughout the state sponsored a variety of entertainment functions and other appropriate projects.

Among the counties in which a special proclamation was issued were Alachua, Bay and Pinellas.

The Woman's Auxiliary to the Bay County Medical Society entertained members of the Society with a dinner dance. Auxiliary members to the Brevard County Medical Society pinned a red carnation on each physician, and in the evening members of the Society gathered in Melbourne for dinner at which Dr. and Mrs. William J. Creel of Eau Gallie were honor guests. Dr. Creel was the feature speaker for the affair.

A dinner party was given by the Auxiliary to the Broward County Medical Association in Fort Lauderdale to honor members of the society.

The Auxiliary to the Dade County Medical Association observed the day by making a contribution to the American Medical Education Foundation. A feature of the evening was a dinner dance and floor show at a local country club. Special honor was paid to the seven charter members of the Association. Of this group, only Dr. John G. DuPuis of Miami survives.

In observance of the day, members of the Auxiliary to the Duval County Medical Society honored the physicians by distributing red carnations to them and in the evening entertaining at a barbecue dinner.

Each physician in Escambia county was presented a carnation by members of the Auxiliary to the Escambia County Medical Society in honor of members of the medical profession both living and dead. To commemorate the day in Tampa, Auxiliary members to the Hillsborough County Medical Association delivered to each member of the Association a red carnation boutonniere.

In observance of the day in Tallahasse, members of the Auxiliary to the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society greeted the physicians at a local hospital and presented each with a red carnation. Physicians retired from active practice and widows of local doctors were also honored by the Auxiliary.

Members of the Manatee County Medical Society were honored by the Auxiliary with open house at the home of Dr. and Mrs. Willett E. Wentzel at Bradenton. Conversation pieces were the flower arrangements done in containers representative of the various specialties of the local physicians.

The hospital auxiliary of Fernandina Beach observed the day by presenting each physician of the Nassau County Medical Society with a red carnation. To commemorate the day, the Woman's Auxiliary to the Orange County Medical Society presented a carnation to each member of the medical profession. In St. Petersburg, Auxiliary members to the Pinellas County Medical Society were stationed at two hospitals to greet the physicians and pin red carnations in their lapels.

Members of the Palm Beach County Medical Society were honor guests of the Auxiliary at an informal dinner dance. The Auxiliary to the Jackson-Calhoun County Medical Society entertained with dinner at a Marianna hotel and earlier with a party at the home of Dr. and Mrs. Francis M. Watson.

The Woman's Auxiliary to the Seminole County Medical Society requested the ministers of the county to dedicate their sermons to members of the medical profession the Sunday preceding Doctor's Day. The Auxiliary also observed the day by entertaining at a dinner party and by placing flowers on the graves of deceased doctors.

COMPONENT SOCIETY NOTES

Dade

The regular monthly meeting of the Dade County Medical Association was held on May 3. Speakers were Drs. Robert J. Grayson whose subject was "Preventive Mental Hygiene in the Community," and Paul S. Jarrett whose subject was "Present Trend in Mental Health Legislation in Florida."

DeSoto-Hardee-Highlands-Glades

The regular monthly meeting of the DeSoto-Hardee-Highlands-Glades County Medical Society was held at Wauchula May 3. Dr. Morris Waisman of Tampa was guest speaker. His subject was "Sidelights on Dermatologic Diagnosis and Treatment." A discussion period followed the address.

Duval

At the regular monthly meeting of the Duval County Medical Society on May 3, Rear Admiral Charles F. Behrens, Senior Medical Officer, Sixth Naval District, spoke on "Atomic Medicine."

(Continued on page 1080)

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what we are talking about...

1. Lack of moral or legal justification in providing federal medical care for ALL veterans
2. Effect of the VA program on civilian medical training programs
3. Current and eventual effects of VA program on civilian health standards
4. Competition for health personnel and patients
5. Unsound economics of overlapping federal medical services
6. Expanding tax-burden
7. Veterans' attitude toward VA medical program



These seven points are the conclusions of a careful analysis by the medical profession of the current VA medical program. (1) Veterans with no service-incurred disability should assume responsibility for their own medical care on the same basis as other citizens. (2) Medical schools and hospitals are hard pressed to train enough medical personnel for the benefit of all as long as the federal government siphons off such personnel from civilian programs. This VA practice has caused a duplication of hospital facilities and an unwarranted dispersion of health personnel. (3) The VA is creating an "artificial" shortage of medical personnel at the expense of civilian health programs. (4) Government has placed itself in competition with civilian medical programs, both for personnel and patients, making it increasingly difficult to operate civilian hospitals efficiently and economically. (5) Although the federal government is spending millions of dollars under the Hill-Burton act in civilian hospital construction, these hospitals are hard pressed to operate at reasonable cost while in direct competition with hospitals **wholly** supported by the federal government. (6) The medical profession asks whether a program providing "free" medical care to veterans with no service-incurred disabilities is a justified burden to impose on the taxpayers of this country. (7) Physicians do not believe that a veteran who served his country wishes to be the recipient of a federal "handout" at the expense of his fellow citizen-taxpayers.

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1. Ruffin, J. M.; Baylin, G. J.; Legerton, C. W., Jr., and Texter, E. C., Jr.: Mechanism of Pain in Peptic Ulcer, Gastroenterology *23*:252 (Feb.) 1953.

2. Schwartz, I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: A Clinical Evaluation of a New Anticholinergic Drug, Pro-Banthine, Gastroenterology *25*:416 (Nov.) 1953.

SEARLE

(Continued from page 1078)

Hillsborough

The regular monthly meeting of the Hillsborough County Medical Association was held on May 3 at the Merrymakers Club on Davis Islands.

Jackson-Calhoun

The regular meeting of the Jackson-Calhoun County Medical Society was held on March 10 at the Chipola Hotel in Marianna.

Lake

The regular monthly meeting of the Lake County Medical Society was held in Mount Dora on April 6.

Dr. Clarence M. Sharp, director of the Bureau of Tuberculosis Control, Florida State Board of Health, Jacksonville, was guest speaker at the regular monthly meeting of the Society held on May 4. Dr. Sharp's subject was "X-Ray Interpretation."

Lee-Charlotte-Collier-Hendry

Dr. Duncan T. McEwan of Orlando was a guest at the regular meeting of the Lee-Charlotte-Collier-Hendry County Medical Society held in Fort Myers March 21.

Marion

The regular meeting of the Marion County Medical Society was held at the Highlands Court Hotel in Ocala on April 19. The Society voted to assist 100 per cent in giving the Salk vaccine to the first and second grade students in the city-county public schools.

Orange

At the regular meeting of the Orange County Medical Society March 16, Dr. Arnold S. Jackson of Madison, Wis., was guest speaker. His subject was diseases of the thyroid.

Palm Beach

The regular monthly meting of the Palm Beach County Medical Society was held March 28 at the Southeast Florida Tuberculosis Hospital at Lantana. Cases of general interest were presented by Dr. William L. Potts, hospital director.

The Palm Beach County Medical Society has paid 100 per cent of its state dues for 1955.

Pinellas

The regular monthly meeting of the Pinellas County Medical Society was held at the Lakewood Country Club on May 2.

Volusia

The regular monthly meeting of the Volusia County Medical Society was held in Daytona Beach on April 12. A program on "Facilities for Rehabilitation of Handicapped Children and Adults in our County," was given by Miss Christine Haukland and Miss Margaret Morgan, Directors of the Junior Service League Orthopedic Center. Following the program the delegates reported on the Florida Medical Association annual meeting in St. Petersburg. A committee headed by Dr. Cleland D. Cochrane and composed of physicians from throughout the county has been set up to work with the public health service on the Salk vaccine program.

The Society has averaged 62 per cent membership attendance at the meetings this year.



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OBITUARIES

Richard Marks Stitt

Dr. Richard Marks Stitt of St. Petersburg died in a local hospital on April 13, 1955. He was 34 years of age.

Born in Leachburg, Pa., on Oct. 24, 1920, Dr. Stitt received his premedical training at Dennison University. He was graduated from Duke University School of Medicine in 1946. He interned at Duke Hospital in Durham, N. C., before serving with the United States Navy on Truk Island in the South Pacific from 1947 to 1949. He was a member of the Beta Theta Pi fraternity at Dennison University and the Phi Chi medical fraternity at Duke University.

Dr. Stitt came to St. Petersburg two and a half years ago from Cleveland, Ohio, and engaged in the private practice of internal medicine, majoring in gastroenterology. Locally he was on the staff of both Mound Park and St. Anthony's hospitals.

A member of the Pinellas County Medical Society since June 1953, Dr. Stitt was also a member of the Florida Medical Association and the American Medical Association.

Surviving are the widow, Mrs. Jane Stitt, a daughter, Anne Bladen Stitt, and two sons, Geoffrey and Richard Marks Stitt Jr., all of St. Petersburg; one brother, John P. Stitt, of Birmingham, Mich., and one sister, Mrs. J. O. Tavenner, of Aurora, Ohio.

Albert Lee Ward

Dr. Albert Lee Ward of Port St. Joe died of a heart attack at his home on March 27, 1955. He was 42 years of age.

A native Floridian, Dr. Ward was born at DeFuniak Springs on Jan. 20, 1913. Upon graduation from high school there, he attended Tulane University of Louisiana and was awarded the degree of Doctor of Medicine by the School of Medicine of that institution in 1936. He then served an internship at the Sacred Heart Hospital in Pensacola and in 1938 completed his training as resident physician at Pensacola Hospital.

Since that time Dr. Ward had engaged in the private practice of medicine in Port St. Joe and had served as surgeon for the railroad and for local paper and lumber mills. Active in civic and church circles, he was a member of the First Methodist Church and served on its board of stewards. He was a member of the Rotary Club and the local club's first president. He was a Mason and a Shriner, and also a member of the Loyal Order of Moose.

Dr. Ward was a member of the Franklin-Gulf County Medical Society and had served for three years as its president. For 18 years he had held membership in the Florida Medical Association, and he was also a member of the American Medical Association. Since 1951 he had been a member of the Florida State Board of Health.

Surviving are the widow, Mrs. Monica Lister Ward, and three daughters, Bobbie, Betty and Brenda, all of Port St. Joe. Other survivors include his mother, Mrs. George W. Ward, of Mobile, Ala.; three brothers, Massey, George and Conley Ward, also of Mobile; and two sisters, Mrs. Marjorie Gaines, of New Iberia, La., and Dr. Mildred Best, of San Antonio, Texas.



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Never a Lost Moment with Auxiliary Members

The convention lights weren't even dimmed in St. Petersburg before the new officers and chairmen of the Woman's Auxiliary to the Florida Medical Association were off for a racing start on another good year in auxiliary work in Florida.

Elected to office at the convention were the following: President: Mrs. Samuel S. Lombardo, Jacksonville; President-elect: Mrs. Scottie J. Wilson, Fort Lauderdale; First Vice President: Mrs. Edward W. Cullipher, Miami; Second Vice President: Mrs Sidney G. Kennedy Jr., Pensacola; Third Vice President: Mrs. John D. Bloom, Groveland; Fourth Vice President: Mrs. William A. Hodges Jr., Lakeland; Recording Secretary: Mrs. Leffie M. Carlton Jr., Tampa; and Treasurer: Mrs. Edward W. Ludwig, Jacksonville.

The officers were installed by Mrs. George Turner, President of the Woman's Auxiliary to the American Medical Association, an honor guest at the Auxiliary meeting.

Plans have been made for outgoing chairmen and officers to work with the incoming officers for a period of two months in order to have continuity in the program and to have no moment lost between the two administrations. The Auxiliary is particularly appreciative of Dr. John D. Milton, then President-elect of the Florida Medical Association and now President, for taking time to come and address us. It was a great boost to have Dr. Wiley M. Sams and Dr. Charles R. Sias from our advisory committee on hand for our meeting. Dr. Sams' remarks were well taken by the Auxiliary members. The members of the Auxiliary were most appreciative also of their inclusion by invitation to attend the opening Scientific Session and for the opportunity to hear the fine address by Dr. Elmer Hess. All of us also want to thank the Florida Medical Association and Dr. Duncan T. McEwan for the kind invitation to hear his address at the opening session of the House of Delegates and for the recognition given the Auxiliary.

It was much easier to write about the events at the convention in 1954 than it is for me to write about them this year. Having been the presiding officer this year, my perspective is perhaps not too objective. However, I think most will agree that although Monday was a long day for Auxiliary members, it was a worthwhile day, with opportunity to take care of the business, hear the fine addresses made to us and take stock of things for the year to come. Further, though the year of work was one of happiness and success for the president, her success and happiness were based on the cooperation and friendliness of each Auxiliary member, without which, the report which has gone to the national auxiliary for the year would have reflected losses rather than the terrific gain in activity it shows.

We are now 1,723 strong, 268 more than in 1953-54 and consequently we can look to greater



Mrs. Samuel S. Lombardo
President, Woman's Auxiliary

and greater participation in the non-scientific interest of medicine in the year to come.

I am sure that the members of the Florida Medical Association join us in our thanks to George N. Craig, Governor of the State of Indiana, for his splendid address at the annual Auxiliary luncheon and his thought provoking words—words that all of us may ponder over and over and still find as food for thought.

There is an old saying that goes something like this: If promises were horses, beggars could ride. But there is one promise that can be made to the Florida Medical Association which is more than a horse for a beggar to ride—it is the sincere promise of the members of the Auxiliary that they will continue to cooperate and help in every way possible.

The convention is over—if you weren't there, we think you missed something worthwhile. Let's look forward to another year under the leadership of Mrs. Samuel S. Lombardo as president and to her convention rather than pausing too long to reflect on the one just passed.

Mrs. Richard F. Stover

Twenty-Ninth Annual Meeting

Woman's Auxiliary to

The Florida Medical Association

Miami Beach, May 13-16, 1956

BOOKS RECEIVED

Fourth Annual Report on Stress. By Hans Selye, M.D., Ph.D., D.Sc., F.R.S., F. I. C. S., and Gunnar Heuser, M.D. Pp. 749. Price $10.00. Montreal, Canada, Acta, Inc., Medical Publishers, 1954.

In 1950 the monograph "Stress" ("Stress—The Physiology and Pathology of Exposure to Stress, a Treatise Based on the Concept of the General-Adaptation-Syndrome and the Diseases of Adaptation") was written by the senior author with the object of reviewing the entire literature on this topic, including the adaptive hormones and the diseases of adaptation. Since 1951 the Annual Reports on Stress have been published as yearly supplements, which act as an index facilitating the task of keeping abreast of the rapidly growing literature on this subject, which is one of the most actively investigated fields in contemporary medicine. The structure of these Annual Reports, of which the present volume is the fourth, corresponds to that of "Stress," but each volume is an independent entity in itself.

As with the earlier reports, this report consists of a detailed critical review by the editors of the most important problems and results of the year's clinical and laboratory research and a discussion of the Stress-Concept, as it presented itself at the time of publication. Special points currently of interest also are discussed in the form of independent original articles by invited guest-authors who are internationally recognized as leading authorities in their fields.

The second part of the book is a classified index to current literature on Stress, the General Adaptation Syndrome, the adaptive hormones (ACTH, STH, corticoids, adrenergic hormones, et cetera) and allied subjects. The data in this index are classified according to a system specially devised so as to permit — even to the uninitiated — the rapid compilation of the whole world literature, or any topic within the domain of Stress-Research.

The City of Hope. By Samuel H. Golter. Pp. 177. Price, $3.50. New York, G. P. Putnam's Sons, 1954.

The author, who has played a leading part in its development, here gives an unforgettable picture of the unique medical center and truly humanitarian project in Duarte, Calif., known as the City of Hope. From two small tents in the desert near Los Angeles in 1913, it has grown to a multimillion dollar complex of specialized hospitals, clinics and research laboratories with nationwide support. Started by a few Eastern people in search of health in the pure desert air, it became a large sanatorium for victims of tuberculosis. Today the City of Hope is in the fight also against cancer, leukemia and heart disease. The word "charity" is never heard there, although no patient is ever asked to pay one cent for the highly specialized hospital, surgical and medical care. This great nonsectarian medical center, operated under Jewish auspices, is supported by people in all walks of life, of every race, religion and creed, through chartered auxiliaries all over the country and voluntary contributions from organizations and individuals.

Mr. Golter relates in the book the circumstances of his own life as they pertain to the development of the institution's idealistic philosophy which considers treatment for the spirit as vital as treatment for the body. He tells the story to his 17 year old daughter because he believes the human values practiced at the City of Hope can be used as a pattern by her generation for building a better world. His message carries hope and inspiration to anyone who has ever faced the problems of major illness, as well as those who are concerned with this ailing world.

Public Relations in Medical Practice. By James E. Bryan. Pp. 301. Price, $5.00. Baltimore, The Williams & Wilkins Company, 1954.

This practical, extremely readable analysis of public relations in medicine is presented from the author's viewpoint that the traditional ethics of the profession — its ideals and code of conduct—are the immutable foundations upon which any public relations program must be based. The approach is that public relations is a practical, sincere method of conduct, not a bag of "gimmicks."

The whole scope of a doctor's activity is covered in this volume, which should be required reading for every physician. It includes the personal, financial, employer and host, ethical, social, guild, economic and institutional relationships, and the final chapter is devoted to The Doctor and Himself. Herein is much food for thought. Says Dr. Louis H. Bauer in the Foreword, "If every physician would give careful consideration to the problems presented herein, follow those suggestions with which he agrees, and suggest better solutions for those with which he disagrees, our public relations would soon reach a high level."

Drugs in Current Use 1955. Edited by Walter Modell, M.D. Pp. 160. Price, $2.00. New York, Springer Publishing Company, Inc., 1955.

Here is a capsule account of the data essential to the sensible exploitation and safe handling of a thousand drugs in current use, listed in alphabetical order under their proprietary and their official names. These data include principal pharmacologic characteristics; major uses; physical properties, absorption; therapeutic and toxic actions; mode of administration; preparations in common use; dosage; available antidotes; and warnings relating to dangerous reactions, contraindications, instability of drugs, storage requirements, and potency loss or changes. Also there are essays on pharmacologic groups, with lists of drugs, and therapeutic groups, with lists. The metric system is used, and there are conversion tables to the apothecary system.

A pharmacologist as well as a practicing internist, Dr. Modell is Associate Professor of Clinical Pharmacology at Cornell University Medical College. He is keenly aware of the drug problems and situations with which a physician is faced and is astute in the selection of information that is essential and likely to be needed in practice. It is the intention to keep this volume up to date by annual revisions. It is to be published entirely new each January.

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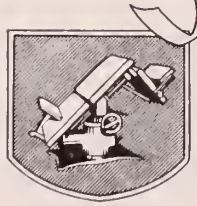
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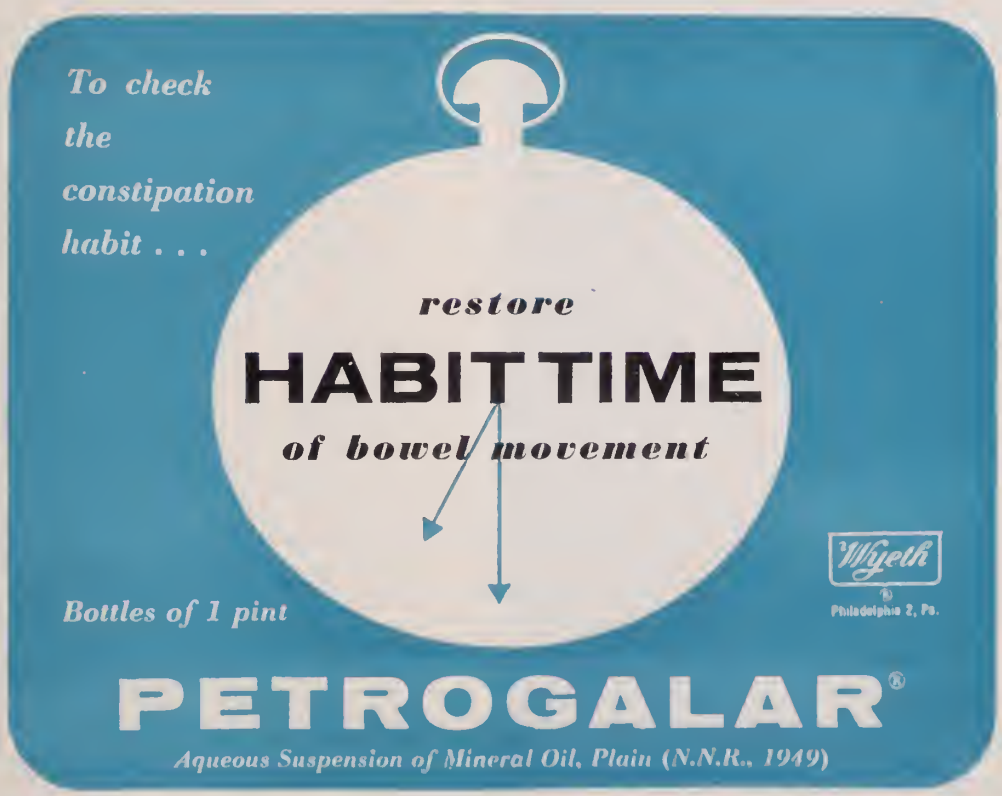
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Bumbalo, T. S., Gustina, F. J., and Oleksiak, R. E.: J. Pediat. 44:386, 1954.

White, R. H. R., and Standen, O. D.: Brit. M. J. 2:755, 1953.

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Brown, H. W.: J. Pediat. 45:419, 1954.

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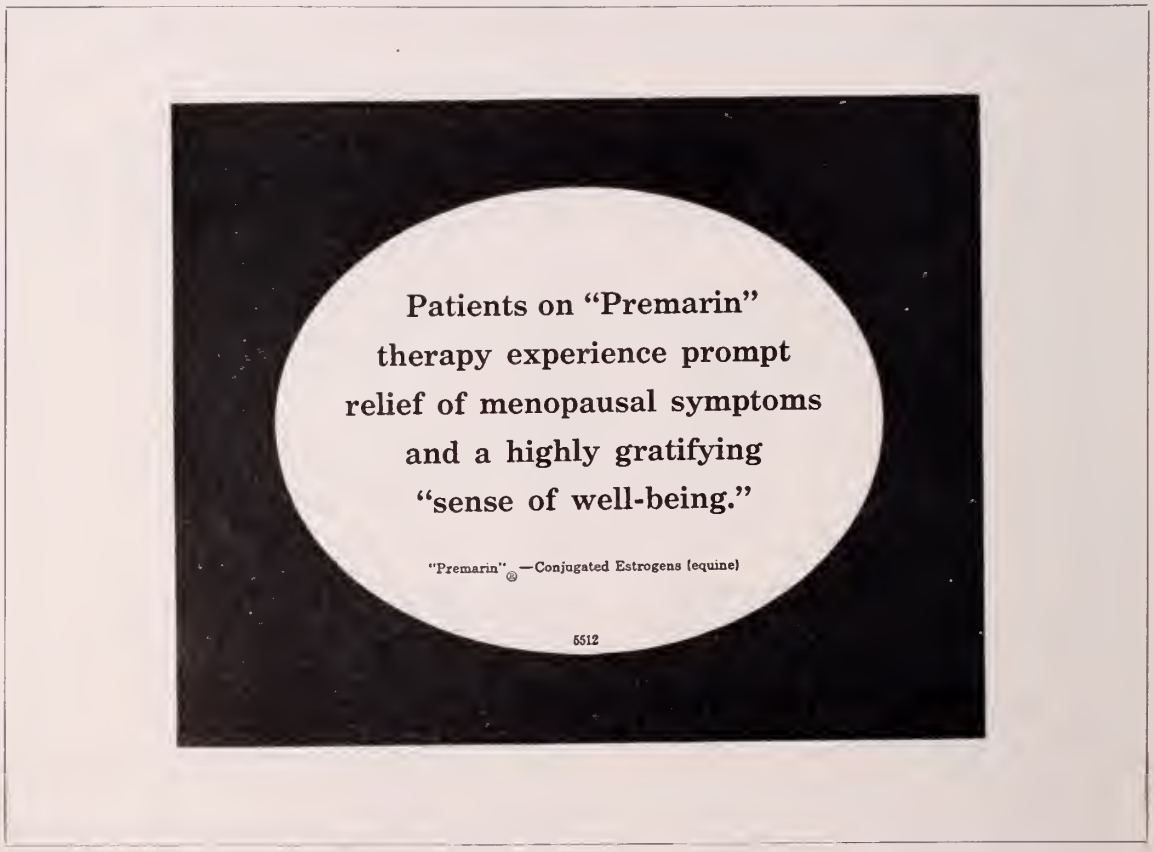
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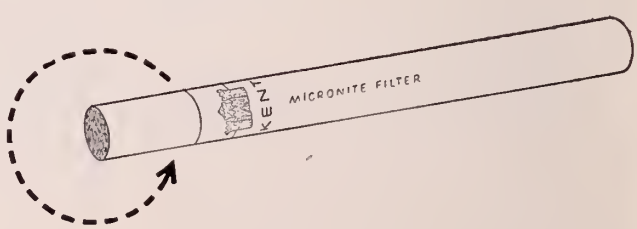
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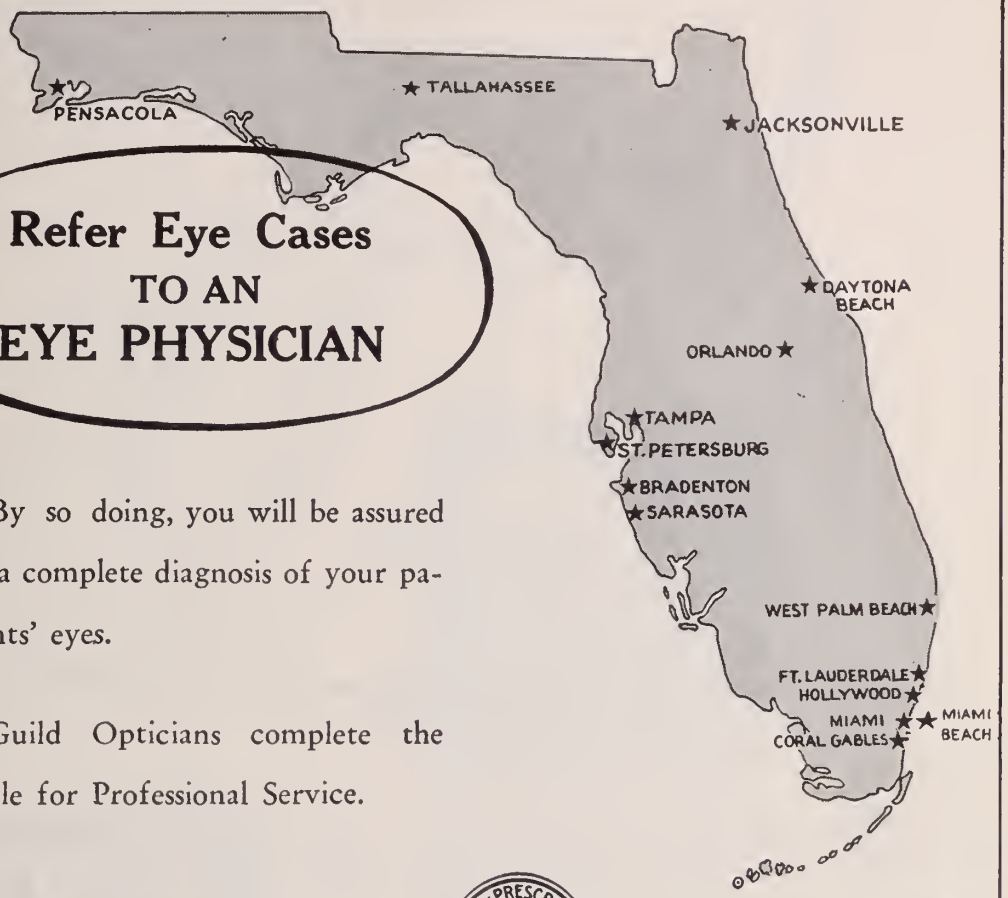
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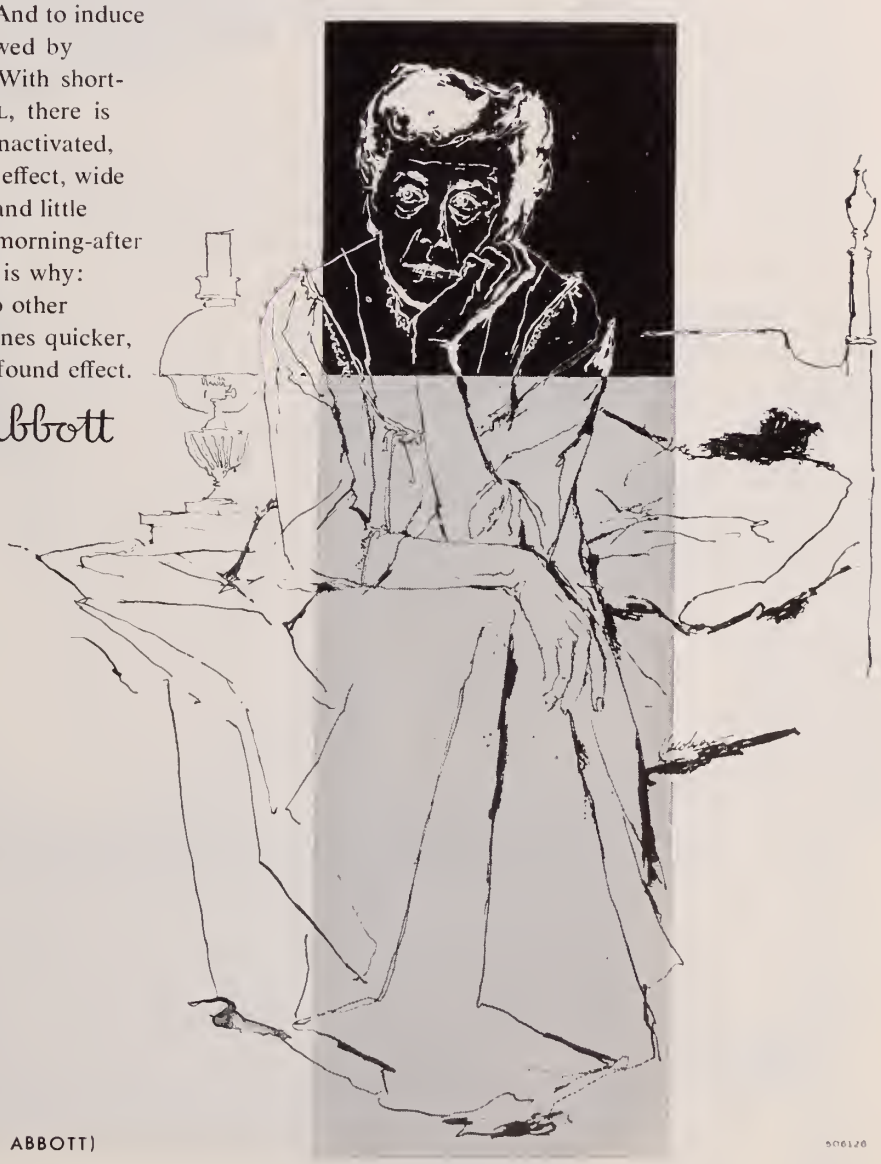
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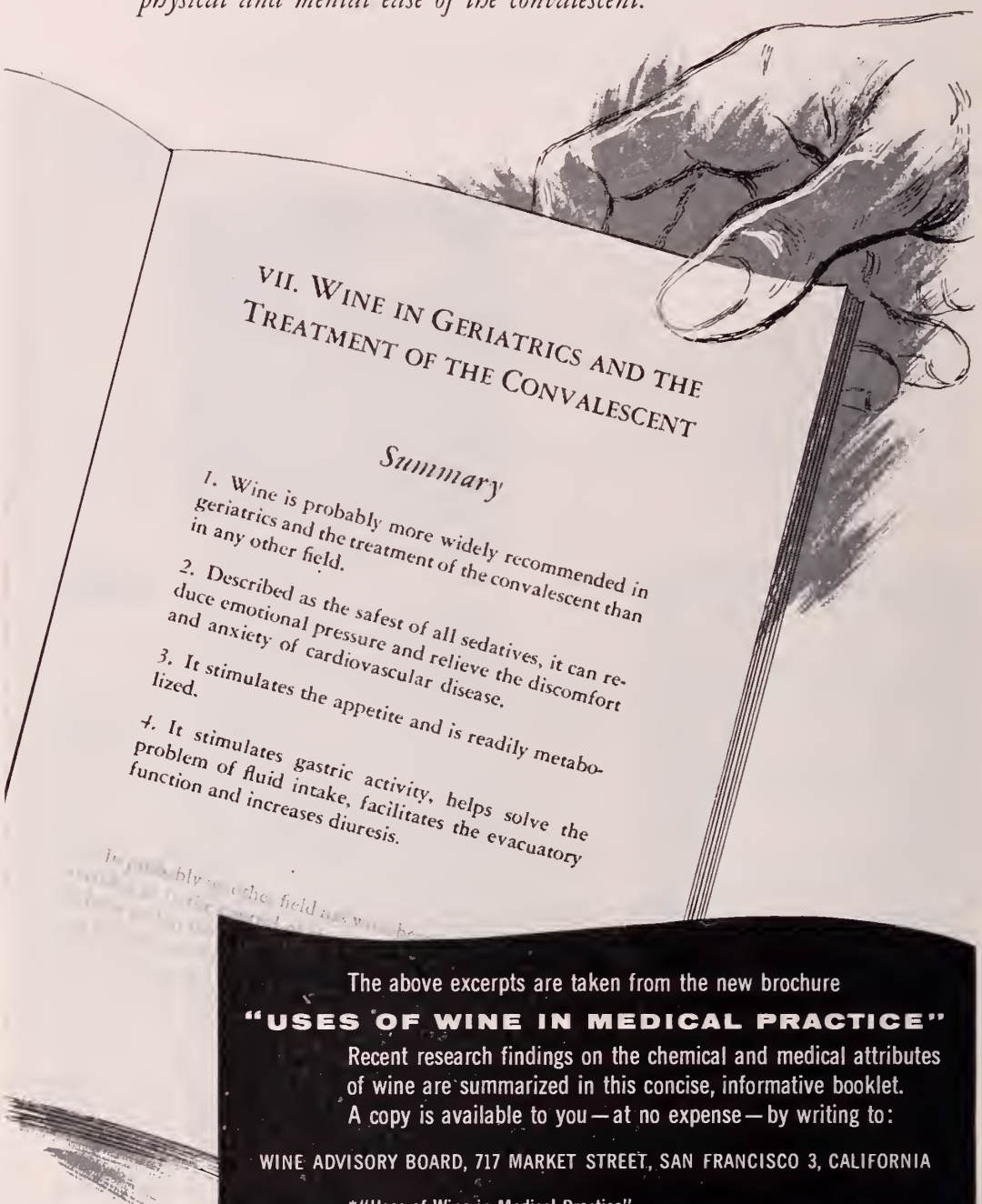
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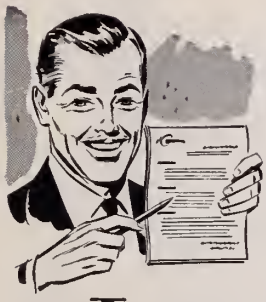
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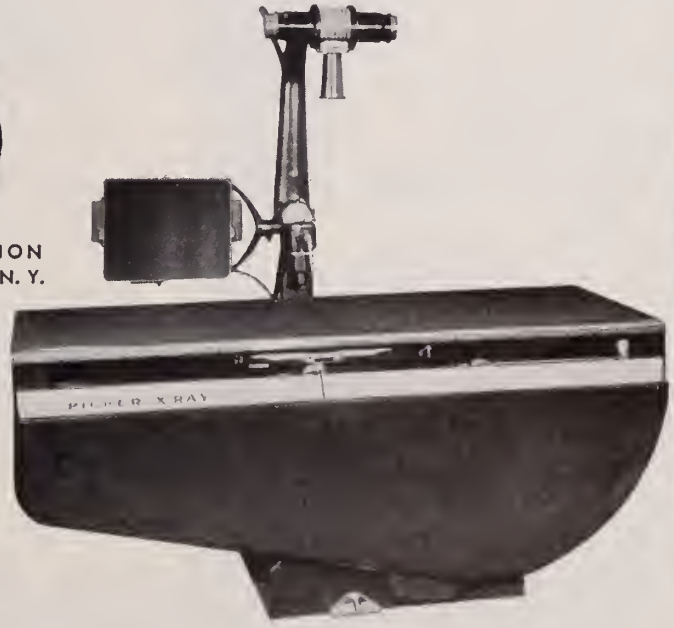
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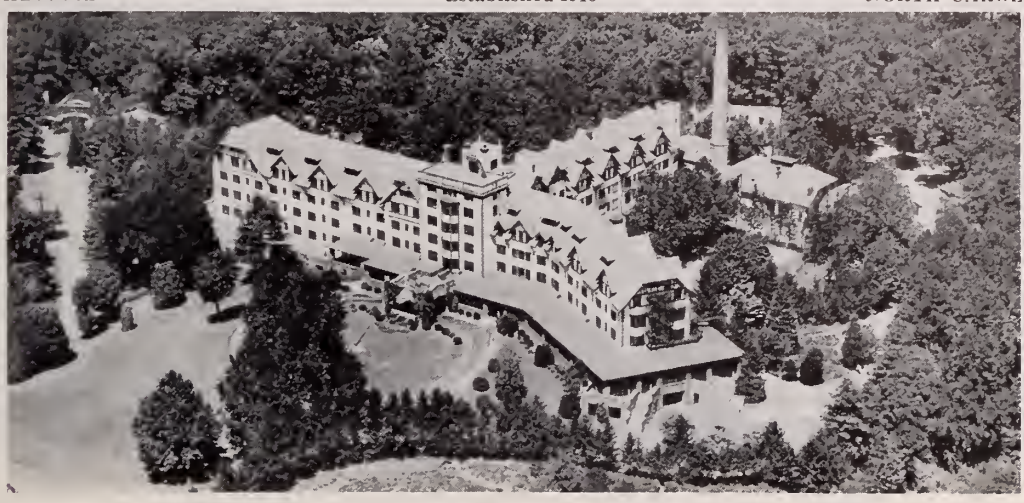
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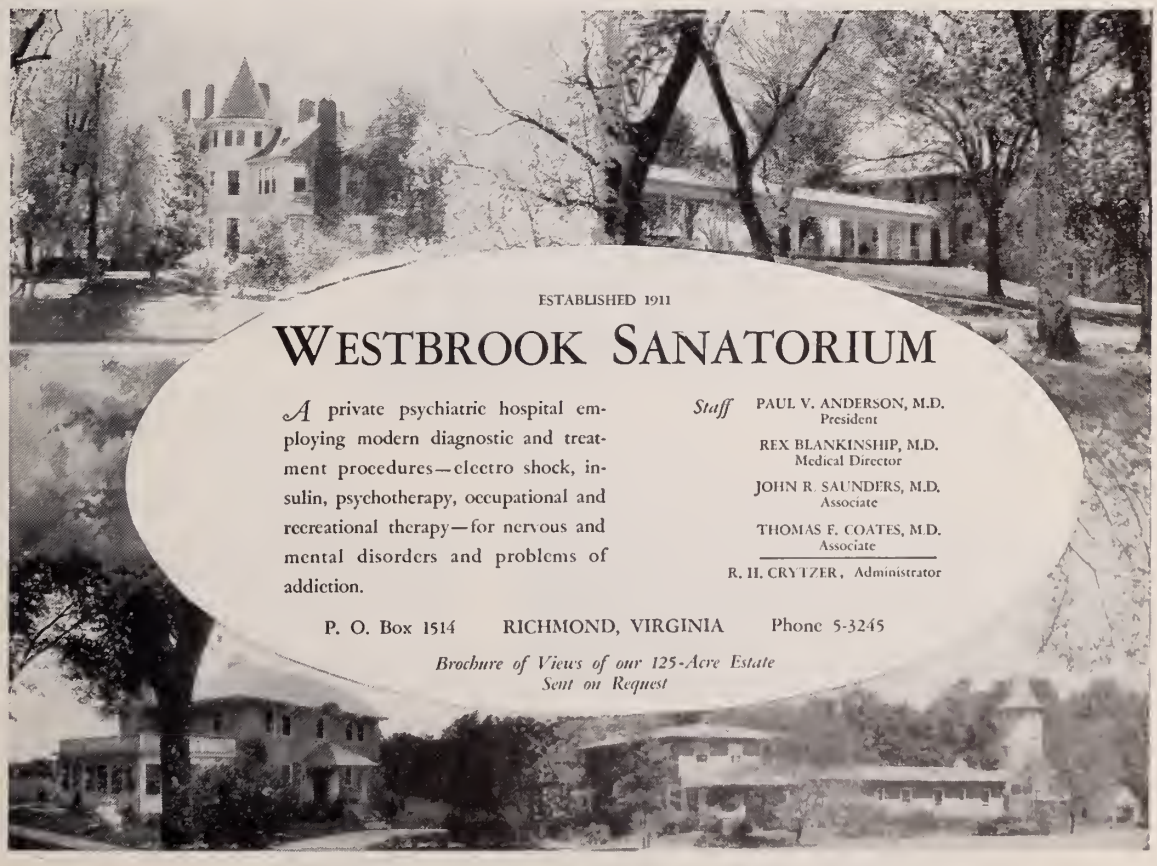
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
lorida Medical Association	John D. Milton, Miami	Samuel M. Day, Jacksonville	Miami Beach, May 13-16, '56
lorida Medical Districts	Ralph W. Jack, Miami	Council Chairman	
A-Northwest	William P. Hixon, Pensacola	Walter J. Baker, Foley	Pensacola
B-Northeast	Henry J. Babers Jr., Gainesville	Charles L. Park Sr., Sanford	Gainesville
C-Southwest	C. Frank Chunn, Tampa	James R. Boulware Jr., Lakeland	Lakeland
D-Southeast	James R. Sory, West Palm Beach	Ralph S. Sappenfield, Miami	Fort Lauderdale
lorida Specialty Societies			
cademy of General Practice	Frank T. Linz, Tampa	James B. Hodge Jr., Tampa	
llergy Society	W. Ambrose McGee, W. P. Bch.	Norris M. Beasley, Ft. Lauderdale	
nesthesiologists, Soc. of	Wayland T. Coppedge Jr., Jax.	William H. Houston, Jacksonville	
hest Phys., Am. Coll., Fla. Chap.	Hawley H. Seiler, Tampa	William L. Potts, Lantana	
)erm. and Syph., Assn. of	Hollis F. Garrard, Miami	Kenneth J. Weiler, St. Petersburg	
'ealth Officers' Society	Clarence L. Brumback, W. P. Bch.	Lorenzo L. Parks, Jacksonville	
ıdustrial and Railway Surgeons	Frank L. Fort, Jacksonville	John H. Mitchell, Jacksonville	
'eurology & Psychiatry	Edward H. Williams, Miami	J. Robert Campbell, Tampa	
b. and Gynec. Society	J. Champneys Taylor, J'sonville	Reuben B. Chrisman Jr., Miami	
phthal. & Otol., Soc. of	Charles W. Boyd, Jacksonville	Kenneth S. Whitmer, Miami	
rthopedic Society	Edward W. Cullipher, Miami	Robert P. Keiser, Coral Gables	
athologists, Society of	Millard B. White, Sarasota	Wray D. Storey, Tampa	
ediatric Society	Wesley S. Nock, Coral Gables	Joel V. McCall Jr., Daytona Beach	
roctologic Society	Thomas F. Nelson, Tampa	George Williams Jr., Miami	
adiological Society	Hugh G. Reaves, Sarasota	Donald H. Gahagen, Ft. Lauderdale	
urgeons, Am. Coll., Fla. Chapter	Joseph S. Stewart, Miami	C. Frank Chunn, Tampa	
rological Society	David W. Goddard, Daytona Bch.	W. Dotson Wells, Fort Lauderdale	
lorida—			
Basic Science Exam Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	
Blood Banks, Association	John T. Stage, Jacksonville	John B. Ross, Jacksonville	St. Petersburg, 1955
Blue Cross of Florida, Inc.	Mr. C. Dewitt Miller. Orlando	Mr. H. A. Schroder, Jacksonville	
Blue Shield of Florida, Inc.	Russell B. Carson, Ft. Lauderdale	John T. Stage, Jacksonvile	
Cancer Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	Miami Beach, May 13, '56
Clinical Diabetes Assn.	Sidney Davidson, Lake Worth	Edward R. Smith, Jacksonville	Daytona Beach, Oct. 20-21, '55
Dental Society, State	T. A. Price, D.D.S., Miami	W. A. Buhner, D.D.S., Daytona Bch.	Miami Beach, May 9-11, '56
Heart Association	Victor H. Kugel, Miami Beach	Daniel R. Usdin, Jacksonville	
Hospital Association	Mr. Pat N. Groner, Pensacola	Mr. Steve F. McCrimmon, C. Gbls.	St. Petersburg, Nov. 16-18, '55
Medical Examining Board	Frank D. Gray, Orlando	Homer L. Pearson Jr., Miami	
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, June 20-24, '55
Nurse Anesthetists, Fla. Assn.	Miss Dorothy Jackson, C. Gables	Mrs. Lalla F. Bryan, Miami	St. Petersburg, Dec. 6-8, '55
Nurses Association, State	Martha Wolfe, R.N., Coral Gables	Agnes Anderson, R.N., Orlando	Daytona Beach, Nov. 28-30 '55
Pharmaceutical Association, State	Mr. J. L. McDonald, St. Augustine	Mr. R. Q. Richards, Ft. Myers	
Public Health Association	Mr. J. A. Mulrennan, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Daytona Beach, Oct. 20-22, '55
Trudeau Society	Lawrence C. Manni, Tallahassee	Simon D. Doff, Jacksonville	
Tuberculosis & Health Assn.	Judge Ernest E. Mason, Pensacola	Mrs. W. J. Norton, Sarasota	
Woman's Auxiliary	Mrs. Samuel Lombardo, J'sonville	Mrs. Leffie M. Carlton Jr., Tampa	Miami Beach, May 13-16, '56
merican Medical Association	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	Atlantic City, June 6-10, '55
A.M.A. Clinical Session	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	Boston, Nov. 29-Dec. 2, '55
uthern Medical Association	Robt. L. Sanders, Memphis, Tenn.	Mr. V. O. Foster, Birmingham	Houston, Nov. 14-17, '55
labama Medical Association	F. L. Chenault, Decatur	Douglas L. Cannon, Montgomery	Birmingham, Apr. 19-21, '56
eorgia, Medical Assn. of	Peter B. Wright, Augusta	David Henry Poer, Atlanta	
E. Hospital Conference	Mr. D. O. McClusky Jr., Tuscaloosa, Ala.	Mr. Pat Groner, Pensacola	Miami Beach, Apr. 18-20, '56
utheastern Allergy Assn.	Ben Miller, Columbia, S. C.	Kath. B. MacInnis, Columbia, S. C.	Charlotte, N. C., Oct. '56
utheastern, Am. Urological Assn.	Sidney Smith, Raleigh, N. C.	Robert F. Sharp, New Orleans	Hollywood, Mar. 25-29, '56
utheastern Surgical Congress	Donald S. Daniel, Richmond	B. T. Beasley, Atlanta	Richmond, Mar. 12-15, '56
ulf Coast Clinical Society	Walter C. Payne Sr., Pensacola	Barkley Beidleman, Pensacola	Pensacola, Oct. 27-28, 1955

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County Medical Societies of Florida

SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Total Members
Alachua	Edwin H. Andrews, Gainesville	Henry S. Blank, Gainesville	2nd Tues.	56
***Bradford, Gilchrist, Union**				
Bay	William F. Humphreys Jr., Panama City	Roderick C. Webb, Panama City	1st Tues.	27
Brevard	Lee Rogers Jr., Cocoa	Charles E. Russell, Cocoa	2nd Tues.	36
Broward	Ernest E. Serrano, Hollywood	Alfred E. Cronkite, Fort Lauderdale	4th Tues.	122
Columbia	Robert B. Harkness, Lake City	Thomas H. Bates, Lake City	1st Mon.	11
***Baker, Hamilton**				
Dade	L. Washington Dowlen, Miami	Robert F. Dickey, Miami	1st Tues	715
De-Soto-Hardee-Highlands-Glades	Gordon H. McSwain, Arcadia	Harold S. Agnew, Arcadia	1st Tues.	28
Duval	Raymond H. King, Jacksonville	Eugene M. Frame, Jacksonville	1st Tues.	300
***Clay**				
Escambia	George W. Morse, Pensacola	Paul F. Baranco, Pensacola	2nd Tues.	107
***Santa Rosa**				
Franklin-Gulf	Warren T. Weathington, Apalachicola	Joseph P. Hendrix, Port St. Joe	Last Wed.	6
Hillsborough	Frank S. Adamo, Tampa	Julien C. Pate Jr., Tampa	1st Tues.	187
Indian River	Kip G. Kelso, Vero Beach	Vernon L. Fromang, Vero Beach	2nd Tues.	10
Jackson-Calhoun	Henry I. Langston, Marianna	Francis M. Watson, Marianna	Quarterly	17
Lake	Louis R. Bowen, Eustis	J. Basil Hall, Tavares	1st Wed.	30
***Sumter**				
Lee-Charlotte-Collier-Hendry	Baker Whisnant, Fort Myers	James L. Bradley, Fort Myers	3rd Mon.	39
Leon-Gadsden-Liberty-Wakulla-Jefferson	William L. Hunter, Monticello	Odis G. Kendrick Jr., Tallahassee	Quarterly	67
Madison	A. Franklin Harrison, Madison	Wallace E. Winter, Madison		6
Manatee	Marjorie L. Warner, Bradenton	Harvey C. Pauley Jr., Bradenton	2nd Tues.	30
Marion	William H. Turnley, Ocala	Bertrand F. Drake, Dunnellon	3rd Tues.	30
***Levy**				14
Monroe	Ralph Herz, Key West	William R. Ploss, Key West	1st Thurs.	
Nassau	David G. Humphreys, Fernandina Beach	John W. McClane, Fernandina Beach	Last Fri.	11
Orange	Don C. Robertson, Orlando	Walter A. Derrick, Orlando	3rd Wed.	193
***Osceola**				
Palm Beach	Edwin W. Brown, West Palm Beach	James R. Anderson, West Palm Beach	4th Mon.	140
Pasco-Hernando-Citrus	Harry G. Brownlee, Zephyrhills	W. Wardlaw Jones, Dade City	2nd Thurs	16
Pinellas	Clyde O. Anderson, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	226
Polk	Samuel J. Clark, Lakeland	Marion W. Hester, Lakeland	2nd Wed.	101
Putnam	Grover C. Collins, Palatka	Alfred P. Peretti, Palatka	2nd Tues.	10
St. Johns	George C. Hopkins, St. Augustine	Reuben J. Plant Jr., St. Augustine	3rd Tues.	21
St. Lucie-Okeechobee-Martin	Henry E. Branca, Fort Pierce	Adrian M. Sample, Fort Pierce	3rd Thurs.	22
Sarasota	Melvin M. Simmons, Sarasota	Andrew J. Jesacher, Sarasota	2nd Tues.	60
Seminole	John M. Morgan, Sanford	Terry Bird, Sanford	2nd Tues.	20
Suwannee	William P. Blackmon, Mayo	Hiram B. Curry, Jasper	1st Sat.	10
Taylor	John H. Parker Jr., Perry	Ralph J. Greene, Perry	Last Fri.	5
***Dixie, Lafayette**				
Volusia	Robert L. Miller, Daytona Beach	Achille A. Monaco, Daytona Beach	2nd Tues.	86
***Flagler**				
Walton-Okaloosa	Richard H. Lee, Crestview	Frederic E. Caldwell, Fort Walton Beach	3rd Tues	20
Washington-Holmes	L. H. Paul, Bonifay	Bayllye W. Dalton, Chipley		5
				Total 2,784

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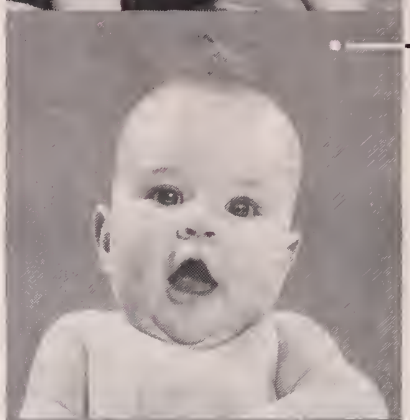


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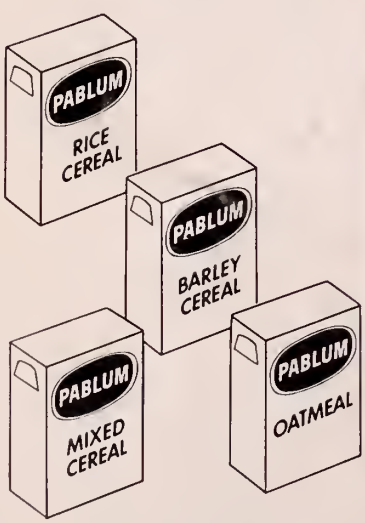


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